

**LEGISLATIVE HISTORY
TITLES I-XX
OF THE
SOCIAL SECURITY ACT**

**Volume XXIV
101st Congress
1989-1990**

Part 2



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**Legislative History of
Titles I-XX
of the Social Security Act**

**Volume XXIV
101st Congress
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Part 2

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101ST CONGRESS
1st Session

HOUSE OF REPRESENTATIVES

REPORT
101-386

OMNIBUS BUDGET RECONCILIATION ACT OF 1989

CONFERENCE REPORT

TO ACCOMPANY

H.R. 3299



NOVEMBER 21, 1989.—Ordered to be printed

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OMNIBUS BUDGET RECONCILIATION ACT OF 1989

NOVEMBER 21, 1989.—Ordered to be printed

Mr. PANETTA, from the committee of conference,
submitted the following

CONFERENCE REPORT

[To accompany H.R. 3299]

The committee of conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 3299) to provide for reconciliation pursuant to section 5 of the concurrent resolution on the budget for the fiscal year 1990, having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows:

That the House recede from its disagreement to the amendment of the Senate and agree to the same with an amendment as follows:

In lieu of the matter proposed to be inserted by the Senate amendment insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the "Omnibus Budget Reconciliation Act of 1989".

SEC. 2. TABLE OF CONTENTS.

Title I—Agriculture and related programs.

Title II—Student loan and pension fiduciary amendments.

Title III—Regulatory agency fees.

Title IV—Civil service and postal service programs.

Title V—Veterans programs.

Title VI—Medicare, medicaid, maternal and child health, and other health provisions.

Title VII—Revenue provisions.

Title VIII—Human resource and income security provisions.

Title IX—Offshore oil pollution compensation fund.

Title X—Miscellaneous and technical Social Security Act amendments.

Title XI—Miscellaneous.

ited, without any reduction and for the fiscal year in which the amount is received, as offsetting collections of—

“(1) the revolving fund for which a fee under section 1829 of this title was collected (or was exempted from being collected) at the time of the original guaranty of the loan that was secured by the same property; or

“(2) in any case in which there was no requirement of (or exemption from) a fee at the time of the original guaranty of the loan that was secured by the same property, the Loan Guaranty Revolving Fund; and

the total so credited to any revolving fund for a fiscal year shall offset outlays attributed to such revolving fund during such fiscal year.”

(b) *EFFECTIVE DATE.*—Subsection (e) of section 1833 of title 38, United States Code, as added by subsection (a), shall apply with respect to amounts referred to in such subsection (e) received on or after October 1, 1989.

TITLE VI—MEDICARE, MEDICAID, MATERNAL AND CHILD HEALTH, AND OTHER HEALTH PROVISIONS

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TITLE VI—MEDICARE, MEDICAID, MATERNAL AND CHILD HEALTH, AND OTHER HEALTH PROVISIONS

Subtitle A—Medicare

PART 1—PROVISIONS RELATING TO PART A

Subpart A—General Provisions

SEC. 6001. EXTENSION OF REDUCTIONS UNDER ORIGINAL SEQUESTER ORDER AND APPLICABILITY OF NEW SEQUESTER ORDER.

Notwithstanding any other provision of law (including section 11002 or any other provision of this Act, other than section 6201), the reductions in the amount of payments required under title XVIII of the Social Security Act made by the final sequester order issued by the President on October 16, 1989, pursuant to section 252(b) of the Balanced Budget and Emergency Deficit Control Act of 1985 shall continue to be effective (as provided by sections 252(a)(4)(B) and 256(d)(2) of such Act) through December 31, 1989, with respect to payments for items and services under part A of such title (including payments under section 1886 of such title attributable or allocated to such part). Each such payment made for items and services provided during fiscal year 1990 after such date shall be increased by 1.42 percent above what it would otherwise be under this Act.

SEC. 6002. REDUCTION IN PAYMENTS FOR CAPITAL-RELATED COSTS OF INPATIENT HOSPITAL SERVICES FOR FISCAL YEAR 1990.

Section 1886(g)(3)(A) of the Social Security Act (42 U.S.C. 1395ww(g)(3)(A)) is amended—

- (1) in clause (iii), by striking “and”;
- (2) in clause (iv), by striking the period at the end and inserting “, and”; and
- (3) by adding at the end the following new clause:
“(v) 15 percent for payments attributable to portions of cost reporting periods or discharges (as the case may be) occurring during the period beginning January 1, 1990, and ending September 30, 1990.”

SEC. 6003. PROSPECTIVE PAYMENT HOSPITALS.

(a) CHANGES IN HOSPITAL UPDATE FACTORS.—

(1) **IN GENERAL.**—Section 1886(b)(3)(B)(i) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)(i)) is amended—

- (A) by striking “and” at the end of subclause (IV),
- (B) in subclause (V), by striking “1990” and inserting “1991” and redesignating such subclause as subclause (VI), and
- (C) by inserting after subclause (IV) the following new subclause:
“(V) for fiscal year 1990, the market basket percentage increase plus 4.22 percentage points for hospitals located in a rural area, the market basket percentage increase plus 0.12 percentage points for hospitals located in a large urban area, and the market basket percentage increase minus 0.53 percentage points for hospitals located in other urban areas, and”.

(2) *EFFECTIVE DATE.*—The amendments made by paragraph (1) shall apply to payments for discharges occurring on or after January 1, 1990.

(3) *INDEXING OF FUTURE APPLICABLE PERCENTAGE INCREASES.*—For discharges occurring on or after October 1, 1990, the applicable percentage increase (described in section 1886(b)(3)(B) of the Social Security Act) for discharges occurring during fiscal year 1990 is deemed to have been such percentage increase as amended by paragraph (1).

(b) *REDUCTION IN DRG WEIGHTING FACTORS FOR FISCAL YEAR 1990; FUTURE ANNUAL RECALIBRATION OF DRG WEIGHTS ON BUDGET-NEUTRAL BASIS.*—Section 1886(d)(4)(C) of such Act (42 U.S.C. 1395ww(d)(4)(C)) is amended—

(1) by striking “(C)” and inserting “(C)(i)”; and

(2) by adding at the end the following new clauses:

“(ii) For discharges in fiscal year 1990, the Secretary shall reduce the weighting factor for each diagnosis-related group by 1.22 percent.

“(iii) Any such adjustment under clause (i) for discharges in a fiscal year (beginning with fiscal year 1991) shall be made in a manner that assures that the aggregate payments under this subsection for discharges in the fiscal year are not greater or less than those that would have been made for discharges in the year without such adjustment.

“(iv) The Secretary shall include recommendations with respect to adjustments to weighting factors under clause (i) in the annual report to Congress required under subsection (e)(3)(B).”

(c) *INCREASE IN DISPROPORTIONATE SHARE ADJUSTMENT.*—

(1) *CHANGE IN FORMULA.*—Section 1886(d)(5)(F) of such Act (42 U.S.C. 1395ww(d)(5)(F)) is amended—

(A) in clause (iv)(I), by striking “the following formula” and all that follows through “(as defined in clause (vi));” and inserting “the applicable formula described in clause (vii);”, and

(B) by adding at the end the following new clause:

“(vii) The formula used to determine the disproportionate share adjustment percentage for a cost reporting period for a hospital described in clause (iv)(I) is—

“(I) in the case of such a hospital with a disproportionate patient percentage (as defined in clause (vi)) greater than 20.2, $(P-20.2)(.65) + 5.62$, or

“(II) in the case of any other such hospital, $(P-15)(.6) + 2.5$, where ‘P’ is the hospital’s disproportionate patient percentage (as defined in clause (vi)).”

(2) *TREATMENT OF RURAL HOSPITALS FOR DISPROPORTIONATE SHARE CALCULATION.*—Section 1886(d)(5)(F) of such Act (42 U.S.C. 1395ww(d)(5)(F)), as amended by paragraph (1), is amended—

(A) in clause (iv)—

(i) in subclause (II), by striking “or”,

(ii) in subclause (III), by inserting “in subclause (IV) or (V) or” after “described”,

(iii) by striking the period at the end of subclause (III) and inserting a semicolon, and

(iv) by adding at the end the following new subclauses:

“(IV) is located in a rural area, is classified as a rural referral center under subparagraph (C), and is classified as a sole community hospital under subparagraph (D), is equal to 10 percent or, if greater, the percent determined in accordance with the applicable formula described in clause (viii); or

“(V) is located in a rural area, is classified as a rural referral center under subparagraph (C), and is not classified as a sole community hospital under subparagraph (D), is equal to the percent determined in accordance with the applicable formula described in clause (viii); or

“(VI) is located in a rural area, is classified as a sole community hospital under subparagraph (D), and is not classified as a rural referral center under subparagraph (C), is 10 percent.”,

(B) in clause (v)—

(i) in subclause (III), by striking “area” and inserting “area and is not described in subclause (II)”,

(ii) by redesignating subclauses (II) and (III) as subclauses (III) and (IV), and

(iii) by inserting after subclause (I) the following new subclause:

“(II) 30 percent, if the hospital is located in a rural area and has more than 100 beds, or is located in a rural area and is classified as a sole community hospital under subparagraph (D),”, and

(C) by adding at the end the following new clause:

“(viii) The formula used to determine the disproportionate share adjustment percentage for a cost reporting period for a hospital described in clause (iv)(IV) or (iv)(V) is the percentage determined in accordance with the following formula: $(P-30) \times .6 + 4.0$, where ‘P’ is the hospital’s disproportionate patient percentage (as defined in clause (vi)).”.

(3) INCREASE FOR HOSPITALS WITH DISPROPORTIONATE INDIGENT CARE REVENUES.—Section 1886(d)(5)(F)(iii) of such Act (42 U.S.C. 1395ww(d)(5)(F)(iii)) is amended by striking “25 percent” and inserting “30 percent”.

(4) EFFECTIVE DATE.—The amendments made by this subsection shall apply with respect to discharges occurring on or after April 1, 1990.

(d) EXTENSION OF REGIONAL REFERRAL CENTER CLASSIFICATION.—Any hospital that is classified as a regional referral center under section 1886(d)(5)(C) of the Social Security Act as of September 30, 1989, including a hospital so classified as a result of section 9302(d)(2) of the Omnibus Budget Reconciliation Act of 1986, shall continue to be classified as a regional referral center for cost reporting periods beginning on or after October 1, 1989, and before October 1, 1992.

(e) CRITERIA AND PAYMENT FOR SOLE COMMUNITY HOSPITALS.—

(1) IN GENERAL.—(A) Section 1886(d)(5) of the Social Security Act (42 U.S.C. 1395ww(d)(5)) is amended—

(i) by transferring clause (iv) of subparagraph (C) to the end and by redesignating it as subparagraph (H),

(ii) by transferring clause (iii) of subparagraph (C) to the end and by redesignating it as subparagraph (I),

(iii) in subparagraph (D), by striking “(D)(i)” and inserting “(E)(i)”, and

(iv) by amending clause (ii) of subparagraph (C) to read as follows:

“(D)(i) For any cost reporting period beginning on or after April 1, 1990, with respect to a subsection (d) hospital which is a sole community hospital, payment under paragraph (1)(A) shall be—

“(I) an amount based on 100 percent of the hospital’s target amount for the cost reporting period, as defined in subsection (b)(3)(C), or

“(II) the amount determined under paragraph (1)(A)(iii), whichever results in greater payment to the hospital.

“(ii) In the case of a sole community hospital that experiences, in a cost reporting period compared to the previous cost reporting period, a decrease of more than 5 percent in its total number of inpatient cases due to circumstances beyond its control, the Secretary shall provide for such adjustment to the payment amounts under this subsection (other than under paragraph (9)) as may be necessary to fully compensate the hospital for the fixed costs it incurs in the period in providing inpatient hospital services, including the reasonable cost of maintaining necessary core staff and services.

“(iii) The term ‘sole community hospital’ means any hospital—

“(I) that the Secretary determines is located more than 35 road miles from another hospital, or

“(II) that, by reason of factors such as the time required for an individual to travel to the nearest alternative source of appropriate inpatient care (in accordance with standards promulgated by the Secretary), location, weather conditions, travel conditions, or absence of other like hospitals (as determined by the Secretary), is the sole source of inpatient hospital services reasonably available to individuals in a geographic area who are entitled to benefits under part A.

“(iv) The Secretary shall promulgate a standard for determining whether a hospital meets the criteria for classification as a sole community hospital under clause (iii)(II) because of the time required for an individual to travel to the nearest alternative source of appropriate inpatient care.”

(B) Section 1886(b)(3) of such Act (42 U.S.C. 1395ww(b)(3)), is further amended—

(i) in subparagraph (A), by striking “(A) For purposes of this subsection” and inserting “(A) Except as provided in subparagraph (C), for purposes of this subsection”, and

(ii) by adding at the end the following new subparagraph:

“(C) In the case of a hospital that is a sole community hospital (as defined in subsection (d)(5)(D)(iii)), the term ‘target amount’ means—

“(i) with respect to the first 12-month cost reporting period in which this subparagraph is applied to the hospital—

“(I) the allowable operating costs of inpatient hospital services (as defined in subsection (a)(4)) recognized under this title for the hospital for the 12-month cost reporting period (in this subparagraph referred to as the ‘base cost reporting period’) preceding the first cost reporting period for which this subsection was in effect with respect to such hospital, increased (in a compounded manner) by—

“(II) the applicable percentage increases applied to such hospital under this paragraph for cost reporting periods after the base cost reporting period and up to and including such first 12-month cost reporting period, or

“(ii) with respect to a later cost reporting period, the target amount for the preceding 12-month cost reporting period, increased by the applicable percentage increase under subparagraph (B)(i) for discharges occurring in the fiscal year in which that later cost reporting period begins.

There shall be substituted for the base cost reporting period described in clause (i) a hospital’s cost reporting period (if any) beginning during fiscal year 1987 if such substitution results in an increase in the target amount for the hospital.”.

(2) CONFORMING AMENDMENTS.—Such Act is further amended—

(A) in section 1833(h)(1)(D), by striking “the last sentence of section 1886(d)(5)(C)(ii)” and inserting “section 1886(d)(5)(D)(iii)”;

(B) in section 1886(d)(5)(C)(i)—

(i) by striking “(C)(i)(I)” and inserting “(C)(i)”, and

(ii) by redesignating subclause (II) as clause (ii) and by striking “subclause (I)” each place it appears in such clause and inserting “clause (i)”;

(C) in section 1886(d)(9)(B)(ii)(IV), by striking “(D)(v)” and inserting “(D)(iii)”;

(D) in section 1886(d)(9)(D)—

(i) by striking clause (iv),

(ii) by transferring clause (iii) to the end and redesignating it as clause (iv), and by striking “(C)(iii)” and inserting “(H)”, and

(iii) by redesignating clause (v) as clause (iii); and

(E) in section 1886(g)(3)(B), by striking “(d)(5)(C)(ii)” and inserting “(d)(5)(D)(iii)”.

(3) CONTINUATION OF SOLE COMMUNITY HOSPITAL DESIGNATION FOR CURRENT SOLE COMMUNITY HOSPITALS.—Any hospital classified as a sole community hospital under section 1886(d)(5)(C)(ii) of the Social Security Act on the date of the enactment of this Act that will no longer be classified as a sole community hospital after such date as a result of the amendments made by paragraph (1) shall continue to be classified as a sole community hospital for purposes of section 1886(d)(5)(D) of such Act.

(f) CRITERIA AND PAYMENT FOR MEDICARE-DEPENDENT, SMALL RURAL HOSPITALS.—

(1) CRITERIA.—Section 1886(d)(5) of the Social Security Act (42 U.S.C. 1395ww(d)(5)), as amended by subsection (e)(1)(A), is further amended by inserting after subparagraph (F) the following new subparagraph:

“(G)(i) For any cost reporting period beginning on or after April 1, 1990, and ending on or before March 31, 1993, with respect to a subsection (d) hospital which is a medicare-dependent, small rural hospital, payment under paragraph (1)(A) shall be—

“(I) an amount based on 100 percent of the hospital’s target amount for the cost reporting period, as defined in subsection (b)(3)(D), or

“(II) the amount determined under paragraph (1)(A)(iii), whichever results in the greater payment to the hospital.

“(ii) In the case of a medicare dependent, small rural hospital that experiences, in a cost reporting period compared to the previous cost reporting period, a decrease of more than 5 percent in its total number of inpatient cases due to circumstances beyond its control, the Secretary shall provide for such adjustment to the payment amounts under this subsection (other than under paragraph (9)) as may be necessary to fully compensate the hospital for the fixed costs it incurs in the period in providing inpatient hospital services, including the reasonable cost of maintaining necessary core staff and services.

“(iii) The term ‘medicare-dependent, small rural hospital’ means, with respect to any cost reporting period to which clause (i) applies, any hospital—

“(I) located in a rural area,

“(II) that has not more than 100 beds,

“(III) that is not classified as a sole community hospital under subparagraph (D), and

“(IV) for which not less than 60 percent of its inpatient days or discharges during the cost reporting period beginning in fiscal year 1987 were attributable to inpatients entitled to benefits under part A.”.

(2) PAYMENT.—Section 1886(b)(3) of such Act (42 U.S.C. 1395ww(b)(3)), as amended by subsection (e)(1)(B), is further amended—

(i) in subparagraph (A), by striking “subparagraph (C)” and inserting “subparagraphs (C) and (D)”, and

(ii) by adding at the end the following new subparagraph:

“(D) For cost reporting periods ending on or before March 31, 1993, in the case of a hospital that is a medicare-dependent, small rural hospital (as defined in subsection (d)(5)(G)), the term ‘target amount’ means—

“(i) with respect to the first 12-month cost reporting period in which this subparagraph is applied to the hospital—

“(I) the allowable operating costs of inpatient hospital services (as defined in subsection (a)(4)) recognized under this title for the hospital for the 12-month cost reporting period (in this subparagraph referred to as the ‘base cost reporting period’) preceding the first cost reporting period for which this subsection was in effect with respect to such hospital, increased (in a compounded manner) by—

“(II) the applicable percentage increases applied to such hospital under this paragraph for cost reporting periods after the base cost reporting period and up to and including such first 12-month cost reporting period, or

"(ii) with respect to a later cost reporting period, the target amount for the preceding 12-month cost reporting period, increased by the applicable percentage increase under subparagraph (B)(i) for discharges occurring in the fiscal year in which that later cost reporting period begins.

There shall be substituted for the base cost reporting period described in clause (i) a hospital's cost reporting period (if any) beginning during fiscal year 1987 if such substitution results in an increase in the target amount for the hospital."

(g) ESSENTIAL ACCESS COMMUNITY HOSPITAL PROGRAM.—

(1) ESTABLISHMENT OF PROGRAM.—

(A) IN GENERAL.—Part A of title XVIII of the Social Security Act (42 U.S.C. 1395c et seq.) is amended by adding at the end the following new section:

"ESSENTIAL ACCESS COMMUNITY HOSPITAL PROGRAM

"SEC. 1820. (a) IN GENERAL.—There is hereby established a program under which the Secretary—

"(1) shall make grants to not more than 7 States to carry out the activities described in subsection (d)(1);

"(2) shall make grants to eligible hospitals and facilities (or consortia of hospitals and facilities) to carry out the activities described in subsection (d)(2); and

"(3) shall designate (under subsection (i)) hospitals and facilities located in States receiving grants under paragraph (1) as essential access community hospitals or rural primary care hospitals.

"(b) ELIGIBILITY OF STATES FOR GRANTS.—A State is eligible to receive a grant under subsection (a)(1) only if the State submits to the Secretary, at such time and in such form as the Secretary may require, an application containing—

"(1) assurances that the State—

"(A) has developed, or is in the process of developing, a State rural health care plan that—

"(i) provides for the creation of one or more rural health networks (as defined in subsection (g)) in the State,

"(ii) promotes regionalization of rural health services in the State,

"(iii) improves access to hospital and other health services for rural residents of the State, and

"(iv) enhances the provision of emergency and other transportation services related to health care;

"(B) has developed the rural health care plan described in subparagraph (A) in consultation with the hospital association of the State and rural hospitals located in the State (or, in the case of a State in the process of developing such plan, that assures the Secretary that it will consult with its State hospital association and rural hospitals located in the State in developing such plan); and

"(C) has designated, or is in the process of designating, rural non-profit or public hospitals or facilities located in

the State as essential access community hospitals or rural primary care hospitals within such networks; and

“(2) such other information and assurances as the Secretary may require.

“(c) ELIGIBILITY OF HOSPITALS AND CONSORTIA FOR GRANTS.—

“(1) IN GENERAL.—Except as provided in paragraph (3), a hospital or facility is eligible to receive a grant under subsection (a)(2) only if the hospital or facility—

“(A) is located in a State receiving a grant under subsection (a)(1);

“(B) is designated as an essential access community hospital or a rural primary care hospital by the State in which it is located or is a member of a rural health network (as defined in subsection (g));

“(C) submits to the State in which it is located and to the Secretary, at such time and in such form as the Secretary may require, an application containing such information and assurances as the Secretary may require; and

“(D) the State in which the hospital or facility is located certifies to the Secretary that—

“(i) the receiving of such a grant by the hospital or facility is consistent with the State’s rural health care plan (described in subsection (b)(1)(A)), and

“(ii) the State has approved the application submitted under subparagraph (C).

“(2) TREATMENT OF CONSORTIA.—A consortium of hospitals or facilities each of which is part of the same rural health network is eligible to receive a grant under subsection (a)(2) if each of its members would individually be eligible to receive such a grant.

“(3) ELIGIBILITY OF RPC HOSPITALS NOT LOCATED IN A STATE RECEIVING GRANT.—A facility designated as a rural primary care hospital by the Secretary under subsection (i)(2)(C) shall be eligible to receive a grant under subsection (a)(2).

“(d) ACTIVITIES FOR WHICH GRANTS MAY BE USED.—

“(1) GRANTS TO STATES.—A State shall use a grant received under subsection (a)(1) to carry out the demonstration program established under this section in the State. Such grant may be used for engaging in activities relating to planning and implementing a rural health care plan and rural health networks, designating hospitals or facilities in the State as essential access community hospitals or rural primary care hospitals, and developing and supporting communication and emergency transportation systems.

“(2) GRANTS TO HOSPITALS, FACILITIES, AND CONSORTIA.—A hospital or facility shall use a grant received under subsection (a)(2) to finance the costs it incurs in converting itself to a rural primary care hospital or an essential access community hospital or in becoming part of a rural health network in the State in which it is located, including capital costs, costs incurred in the development of necessary communications systems, and costs incurred in the development of an emergency transportation system. A consortium shall use a grant received under subsection (a)(2) to finance the costs it incurs in converting hospitals

or facilities that are part of the consortium into rural primary care hospitals or in developing and implementing a rural health network consisting of its members in the State in which it is located, including capital costs, costs incurred in the development of necessary communications systems, and costs incurred in the development of an emergency transportation system.

“(e) DESIGNATION BY STATE OF ESSENTIAL ACCESS COMMUNITY HOSPITALS.—A State may designate a hospital as an essential access community hospital only if the hospital—

“(1) is located in a rural area (as defined in section 1886(d)(2)(D));

“(2)(A) is located more than 35 miles from any hospital that either (i) has been designated as an essential access community hospital, (ii) is classified by the Secretary as a rural referral center under section 1886(d)(5)(C), or (iii) is located in an urban area that meets the criteria for classification as a regional referral center under such section, or (B) meets such other criteria relating to geographic location as the State may impose with the approval of the Secretary;

“(3) has at least 75 inpatient beds or is located more than 35 miles from any other hospital;

“(4) has in effect an agreement to provide emergency and medical backup services to rural primary care hospitals participating in the rural health network of which it is a member and throughout its service area;

“(5) has in effect an agreement, with each rural primary care hospital participating in the rural health network of which it is a member, to accept patients transferred from such primary care hospitals, to receive data from and transmit data to such primary care hospitals, and to provide staff privileges to physicians providing care at such primary care hospitals; and

“(6) meets any other requirements imposed by the State with the approval of the Secretary.

“(f) DESIGNATION BY STATE OF RURAL PRIMARY CARE HOSPITALS.—

“(1) CRITERIA FOR DESIGNATION.—A State may designate a facility as a rural primary care hospital only if the facility—

“(A) is located in a rural area (as defined in section 1886(d)(2)(D));

“(B) at the time such facility applies to the State for designation as a rural primary care hospital, is a hospital with a participation agreement in effect under section 1866(a) and had not been found, on the basis of a survey under section 1864, to be in violation of any requirement to participate as a hospital under this title;

“(C) has ceased, or agrees (upon the approval of such application) to cease, providing inpatient care (except as required under subparagraph (F));

“(D) in the case of a facility that is a member of a rural health network, has in effect an agreement to participate with other hospitals and facilities in the communications system of such network, including the network's system for the electronic sharing of patient data, including telemetry

and medical records, if the network has in operation such a system;

“(E) makes available 24-hour emergency care;

“(F) provides not more than 6 inpatient beds (meeting such conditions as the Secretary may establish) for providing inpatient care for a period not to exceed 72 hours (unless a longer period is required because transfer to a hospital is precluded because of inclement weather or other emergency conditions) to patients requiring stabilization before discharge or transfer to a hospital;

“(G) meets such staffing requirements as would apply under section 1861(e) to a hospital located in a rural area, except that—

“(i) the facility need not meet hospital standards relating to the number of hours during a day, or days during a week, in which the facility must be open, except insofar as the facility is required to provide emergency care on a 24-hour basis under subparagraph (E),

“(ii) the facility may provide any services otherwise required to be provided by a full-time, on-site dietician, pharmacist, laboratory technician, medical technologist, and radiological technologist on a part-time, off-site basis, and

“(iii) the inpatient care described in subparagraph (F) may be provided by a physician’s assistant or nurse practitioner, subject to the oversight of a physician; and

“(H) meets the requirements of subparagraphs (C) through (J) of paragraph (2) of section 1861(aa) and of clauses (ii) and (iv) of the second sentence of that paragraph.

“(2) PREFERENCE GIVEN TO HOSPITALS OR FACILITIES PARTICIPATING IN RURAL HEALTH NETWORK.—In designating facilities as rural primary care hospitals under paragraph (1), the State shall give preference to hospitals or facilities participating in a rural health network.

“(3) PERMITTING RURAL PRIMARY CARE HOSPITALS TO MAINTAIN SWING BEDS.—Nothing in this subsection shall be construed to prohibit a State from designating a facility as a rural primary care hospital solely because the facility has entered into an agreement with the Secretary under section 1883 under which the facility’s inpatient hospital facilities may be used for the furnishing of extended care services.

“(g) RURAL HEALTH NETWORK DEFINED.—For purposes of this section, the term ‘rural health network’ means, with respect to a State, an organization—

“(1) consisting of—

“(A) at least 1 hospital that—

“(i) the State has designated or plans to designate as an essential access community hospital under subsection (b)(1)(C),

“(ii) is classified by the Secretary as rural referral center under section 1886(d)(5)(C), or

“(iii) is located in an urban area and meets the criteria for classification as a regional referral center under such section, and

“(B) at least 1 facility that the State has designated or plans to designate as a rural primary care hospital, and

“(2) the members of which have entered into agreements regarding—

“(A) patient referral and transfer,

“(B) the development and use of communications systems, including (where feasible) telemetry systems and systems for electronic sharing of patient data, and

“(C) the provision of emergency and non-emergency transportation among the members.

“(h) LIMIT ON AMOUNT OF GRANT TO HOSPITAL OR FACILITY.—A grant made to a hospital or facility under subsection (a)(2) may not exceed \$200,000.

“(i) ELIGIBILITY OF HOSPITALS OR FACILITIES FOR DESIGNATION BY SECRETARY.—

“(1) ESSENTIAL ACCESS COMMUNITY HOSPITAL.—(A) The Secretary shall designate a hospital as an essential access community hospital if the hospital—

“(i) is located in a State receiving a grant under subsection (a)(1);

“(ii) is designated as an essential access community hospital by the State in which it is located (except as provided in subparagraph (B)); and

“(iii) meets such other criteria as the Secretary may require.

“(B) In the case of a hospital that is not eligible for designation as an essential access community hospital under this paragraph solely because it is not designated as an essential access community hospital by the State in which it is located, the Secretary may designate such hospital as an essential access community hospital under this paragraph if the hospital is not so designated by the State in which it is located solely because of its failure to meet the criteria described in paragraph (3) of subsection (e).

“(2) RURAL PRIMARY CARE HOSPITAL.—(A) The Secretary shall designate a facility as a rural primary care hospital if the facility—

“(i) is located in a State receiving a grant under subsection (a)(1);

“(ii) is designated as a rural primary care hospital by the State in which it is located (except as provided in subparagraph (B)); and

“(iii) meets such other criteria as the Secretary may require.

“(B) In the case of a facility that is not eligible for designation as a rural primary care hospital under this paragraph solely because it is not designated as a rural primary care hospital by the State in which it is located, the Secretary may designate such facility as a rural primary care hospital under this paragraph if the facility is not so designated by the State in which it is located solely because of its failure to meet the crite-

ria described in subparagraphs (C), (F), or (G) of subsection (f)(1).

“(C) The Secretary may designate not more than 15 facilities as rural primary care hospitals under this paragraph that do not meet the requirements of clauses (i) and (ii) of subparagraph (A) if such a facility meets the criteria described in subparagraphs (A), (B), and (E) of subsection (f)(1), except that nothing in this subparagraph shall be construed to prohibit the Secretary from designating a facility as a rural primary care hospital solely because the facility has entered into an agreement with the Secretary under section 1883 under which the facility’s inpatient hospital facilities may be used for the furnishing of extended care services.

“(j) **WAIVER OF CONFLICTING PART A PROVISIONS.**—The Secretary is authorized to waive such provisions of this part as are necessary to conduct the program established under this section.

“(k) **AUTHORIZATION OF APPROPRIATIONS.**—There are authorized to be appropriated from the Federal Hospital Insurance Trust Fund for each of the fiscal years 1990, 1991, and 1992—

“(1) \$10,000,000 for grants to States under subsection (a)(1); and

“(2) \$15,000,000 for grants to hospitals, facilities, and consortia under subsection (a)(2).”

(B) **MODIFICATION OF RURAL HEALTH CARE TRANSITION GRANT PROGRAM.**—(i) Section 4005(e) of the Omnibus Budget Reconciliation Act of 1987 is amended—

(I) in paragraph (1), by adding at the end the following new sentence: “Grants under this paragraph may be used to provide instruction and consultation (and such other services as the Administrator determines appropriate) via telecommunications to physicians in such rural areas (within the meaning of section 1886(d)(2)(D) of the Social Security Act) as are designated either class 1 or class 2 health manpower shortage areas under section 332(a)(1)(A) of the Public Health Service Act.”,

(II) in paragraph (3)(A), by striking “an application to the Governor” and inserting “an application to the Administrator and a copy of such application to the Governor”,

(III) in paragraph (3)(B), by striking “any application” and all that follows through “accompanied by” and inserting “to the Administrator, within a reasonable time after receiving a copy of an application pursuant to subparagraph (A).”,

(IV) in paragraph (6), by striking “2 years” and inserting “3 years”,

(V) in paragraph (7)(A), by striking “(D)” and inserting “(B)”,

(VI) in paragraph (7)(C), by striking the period at the end and inserting the following: “, except that this limitation shall not apply with respect to a grant used for the purposes described in subparagraph (D).”,

(VII) by adding at the end of paragraph (7) the following new subparagraph:

“(D) A hospital may use a grant received under this subsection to develop a plan for converting itself to a rural primary care hospital (as described in section 1820 of the Social Security Act) or to develop a rural health network (as defined in section 1820(g) of such Act) in the State in which it is located if the State is receiving a grant under section 1820(a)(1).”, and

(VIII) in paragraph (9), by striking “each of the fiscal years 1989 and 1990” and inserting “fiscal year 1989 and \$25,000,000 for each of the fiscal years 1990, 1991, and 1992”.

(ii) The amendments made by clause (i) shall apply with respect to applications for grants under the Rural Health Care Transition Grant Program described in section 4005(e) of the Omnibus Budget Reconciliation Act of 1987 submitted on or after October 1, 1989, except that the amendments made by subclauses (V) and (VII) of such clause shall take effect on the date of the enactment of this Act.

(2) **TREATMENT OF ESSENTIAL ACCESS COMMUNITY HOSPITALS AS SOLE COMMUNITY HOSPITALS.**—Section 1886(d)(5)(D) of such Act (42 U.S.C. 1395ww(d)(5)(D)) (as redesignated and amended by subsection (e)(1)(A)) is further amended—

(A) in clause (iii)—

(i) in subclause (I), by striking “or”,

(ii) in subclause (II), by striking the period at the end and inserting “, or”, and

(iii) by adding at the end the following new subclause:

“(III) that is designated by the Secretary as an essential access community hospital under section 1820(i)(1).”, and

(B) by adding at the end the following new clause:

“(iv) If the Secretary determines that, in the case of a hospital designated by the Secretary as an essential access community hospital under section 1820(i)(1), the hospital has incurred increases in reasonable costs during a cost reporting period as a result of becoming a member of a rural health network (as defined in section 1820(g)) in the State in which it is located, and in incurring such increases, the hospital will increase its costs for subsequent cost reporting periods, the Secretary shall increase the hospital’s target amount under subsection (b)(3)(C) to account for such incurred increases.”.

(3) **COVERAGE OF, AND PAYMENT FOR, INPATIENT RURAL PRIMARY CARE HOSPITAL SERVICES.**—

(A) **DEFINITIONS.**—Section 1861 of such Act (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

“Rural Primary Care Hospital; Rural Primary Care Hospital Services

“(mm)(1) The term ‘rural primary care hospital’ means a facility designated by the Secretary as a rural primary care hospital under section 1820(i)(2).

“(2) The term ‘inpatient rural primary care hospital services’ means items and services, furnished to an inpatient of a rural primary care hospital by such a hospital, that would be inpatient hospital services if furnished to an inpatient of a hospital by a hospital.”

(B) **COVERAGE AND PAYMENT.**—(i) Section 1812(a)(1) of such Act (42 U.S.C. 1395d(a)(1)) is amended by inserting “and inpatient rural primary care hospital services” after “inpatient hospital services”.

(ii) Section 1814(a) of such Act (42 U.S.C. 1395f(a)) is amended—

(I) by striking “and” at the end of paragraph (6),

(II) by striking the period at the end of paragraph (7) and inserting “; and”, and

(III) by inserting after paragraph (7) the following new paragraph:

“(8) in the case of inpatient rural primary care hospital services, a physician certifies that such services were required to be immediately furnished on a temporary, inpatient basis.”

(iii) Section 1814 of such Act is further amended—

(I) in subsection (b), by inserting “, other than a rural primary care hospital providing inpatient rural primary care hospital services,” after “providing hospice care”, and

(II) by adding at the end the following new subsection:

“Payment for Inpatient Rural Primary Care Hospital Services

“(1)(1) The amount of payment under this part for inpatient rural primary care hospital services—

“(A) in the case of the first 12-month cost reporting period for which the facility operates as such a hospital, is the reasonable costs of the facility in providing inpatient rural primary care hospital services during such period, as such costs are determined on a per diem basis, and

“(B) in the case of a later reporting period, is the per diem payment amount established under this paragraph for the preceding 12-month cost reporting period, increased by the applicable percentage increase under section 1886(b)(3)(B)(i) for that particular cost reporting period applicable to hospitals located in a rural area.

The payment amounts otherwise determined under this paragraph shall be reduced, to the extent necessary, to avoid duplication of any payment made under section 1820(a)(2) (or under section 4005(e) of the Omnibus Budget Reconciliation Act of 1987) to cover the provision of inpatient rural primary care hospital services.

“(2) The Secretary shall develop a prospective payment system for determining payment amounts for inpatient rural primary care hospital services under this part furnished on or after January 1, 1993.”

(C) **TREATMENT OF RURAL PRIMARY CARE HOSPITALS AS PROVIDERS OF SERVICES.**—(i) Section 1861(u) of such Act (42

U.S.C. 1395x(u)) is amended by inserting "rural primary care hospital," after "hospital,".

(ii) Section 1863 of such Act (42 U.S.C. 1395z) is amended by striking "and (jj)(3)" and inserting "(jj)(3), and (mm)(1)".

(iii) The first sentence of section 1864(a) of such Act (42 U.S.C. 1395aa(a)) is amended by inserting ", a rural primary care hospital, as defined in section 1861(mm)(1)," after "1861(aa)(2)".

(iv) The third sentence of section 1865(a) of such Act (42 U.S.C. 1395bb(a)) is amended by striking "or 1861(dd)(2)" and inserting "1861(dd)(2), or 1861(mm)(1)".

(D) CONFORMING AMENDMENTS.—(i) Section 1128A(b)(1) of such Act (42 U.S.C. 1320a-7a(b)(1)) is amended by striking "hospital" and inserting "hospital or a rural primary care hospital".

(ii) Section 1128B(c) of such Act (42 U.S.C. 1320a-7b(c)) is amended by inserting "rural primary care hospital," after "hospital,".

(iii) Section 1134 of such Act (42 U.S.C. 1320b-4) is amended by striking "hospitals" each place it appears and inserting "hospitals or rural primary care hospitals".

(iv) Section 1138(a)(1) of such Act (42 U.S.C. 1320b-8(a)(1)) is amended by striking "hospital" each place it appears in the matter preceding clause (i) of subparagraph (A) and inserting "hospital or rural primary care hospital".

(v) Section 1164(e) of such Act (42 U.S.C. 1320c-13(e)) is amended by inserting "rural primary care hospitals," after "hospitals,".

(vi) Section 1816(c)(2)(C) of such Act (42 U.S.C. 1395h(c)(2)(C)) is amended by inserting "rural primary care hospital," after "hospital,".

(vii) Section 1833 of such Act (42 U.S.C. 1395l) is amended—

(I) in subsection (h)(5)(A)(iii), by striking "hospital," each place it appears and inserting "hospital or a rural primary care hospital,";

(II) in subsection (i)(1)(A), by inserting ", rural primary care hospital," after "1832(a)(2)(F)(i)";

(III) in subsection (i)(3)(A), by inserting "or rural primary care hospital services" after "facility services";

(IV) in subsection (l)(5)(A), by inserting "rural primary care hospital," after "hospital,"; and

(V) in subsection (l)(5)(C), by striking "hospital" each place it appears and inserting "hospital or rural primary care hospital".

(viii) Section 1835(c) of such Act (42 U.S.C. 1395n(c)) is amended by adding at the end the following: "A rural primary care hospital shall be considered a hospital for purposes of this subsection."

(ix) Section 1842(b)(6)(A)(ii) of such Act (42 U.S.C. 1395u(b)(6)(A)(ii)) is amended by inserting "rural primary care hospital," after "hospital,".

(x) Section 1861 of such Act (42 U.S.C. 1395x) is amended—

(I) in subsection (e), by adding at the end the following: "The term 'hospital' does not include, unless the context otherwise requires, a rural primary care hospital (as defined in section 1861(mm)(1)).",

(II) in subsection (w)(1), by inserting "rural primary care hospital," after "hospital," and

(III) in subsection (w)(2), by striking "hospital" each place it appears and inserting "hospital or rural primary care hospital".

(xi) Section 1862(a)(14) of such Act (42 U.S.C. 1395y(a)(14)) is amended by striking "hospital" each place it appears and inserting "hospital or rural primary care hospital".

(xii) Section 1866(a)(1) of such Act (42 U.S.C. 1395cc(a)(1)) is amended—

(I) in subparagraph (F)(ii), by inserting "rural primary care hospitals," after "hospitals,";

(II) in subparagraph (H), by inserting after "this title" the first place it appears the following: "and in the case of rural primary care hospitals which provide rural primary care hospital services";

(III) in subparagraph (I), by inserting "and in the case of a rural primary care hospital" after "hospital"; and

(IV) in subparagraph (N), by striking "hospitals" and "hospital," and inserting "hospitals and rural primary care hospitals" and "hospital or rural primary care hospital," respectively.

(xiii) Section 1866(a)(3) of such Act (42 U.S.C. 1395cc(a)(3)) is amended—

(I) by striking "hospital," each place it appears in subparagraphs (A) and (B) and inserting "hospital, rural primary care hospital," and

(II) in subparagraph (C)(ii)(II), by striking "facilities" each place it appears and inserting "facilities, rural primary care hospitals,".

(xiv) Section 1867(e) of such Act (42 U.S.C. 1395dd(e)) is amended by adding at the end the following new paragraph:

"(6) The term 'hospital' includes a rural primary care hospital (as defined in section 1861(mm)(1)).".

(4) AVOIDING DUPLICATIVE PAYMENTS TO HOSPITALS PARTICIPATING IN RURAL HEALTH CARE TRANSITION GRANTS.—Section 1886 of the Social Security Act (42 U.S.C. 1395ww) is amended by adding at the end the following new subsection:

"(i) AVOIDING DUPLICATIVE PAYMENTS TO HOSPITALS PARTICIPATING IN RURAL DEMONSTRATION PROGRAMS.—The Secretary shall reduce any payment amounts otherwise determined under this section to the extent necessary to avoid duplication of any payment made under section 4005(e) of the Omnibus Budget Reconciliation Act of 1987."

(h) GEOGRAPHIC CLASSIFICATION OF HOSPITALS.—

(1) ESTABLISHMENT OF MEDICARE GEOGRAPHICAL CLASSIFICATION BOARD.—Section 1886(d) of the Social Security Act (42

U.S.C. 1395ww(d)) is amended by adding at the end the following new paragraph:

“(10)(A) There is hereby established the ‘Medicare Geographical Classification Review Board’ (hereinafter in this paragraph referred to as the ‘Board’).

“(B)(i) The Board shall be composed of 5 members appointed by the Secretary without regard to the provisions of title 5, United States Code, governing appointments in the competitive service. Two of such members shall be representatives of subsection (d) hospitals located in a rural area under paragraph (2)(D). At least 1 member shall be a member of the Prospective Payment Assessment Commission, and at least 1 member shall be knowledgeable in the field of analyzing costs with respect to the provision of inpatient hospital services.

“(ii) The Secretary shall make all appointments to the Board as provided in this paragraph within 180 days after the date of the enactment of this paragraph.

“(C)(i) The Board shall consider the application of any subsection (d) hospital requesting that the Secretary change the hospital’s geographic classification for purposes of determining for a fiscal year—

“(I) the hospital’s average standardized amount under paragraph (2)(D), or

“(II) the area wage index applicable to such hospital under paragraph (3)(E).

“(ii) A hospital requesting a change in geographic classification under clause (i) for a fiscal year shall submit its application to the Board not later than the first day of the preceding fiscal year.

“(iii)(I) The Board shall render a decision on an application submitted under clause (i) not later than 180 days after the deadline referred to in clause (ii).

“(II) A decision of the Board shall be final unless the unsuccessful applicant appeals such decision to the Secretary by not later than 15 days after the Board renders its decision. The Secretary in considering the appeal of an applicant shall receive no new evidence but shall consider the record as a whole as such record appeared before the Board. The Secretary shall issue a decision on such an appeal not later than 90 days after the appeal is filed. The decision of the Secretary shall be final and shall not be subject to judicial review.

“(D)(i) The Secretary shall publish guidelines to be utilized by the Board in rendering decisions on applications submitted under this paragraph, and shall include in such guidelines the following:

“(I) Guidelines for comparing wages, taking into account occupational mix, in the area in which the hospital is classified and the area in which the hospital is applying to be classified.

“(II) Guidelines for determining whether the county in which the hospital is located should be treated as being a part of a particular Metropolitan Statistical Area.

“(III) Guidelines for considering information provided by an applicant with respect to the effects of the hospital’s geographic classification on access to inpatient hospital services by medicare beneficiaries.

“(IV) Guidelines for considering the appropriateness of the criteria used to define New England County Metropolitan Areas.

“(ii) The Secretary shall publish the guidelines described in clause (i) by July 1, 1990.

“(E)(i) The Board shall have full power and authority to make rules and establish procedures, not inconsistent with the provisions of this title or regulations of the Secretary, which are necessary or appropriate to carry out the provisions of this paragraph. In the course of any hearing the Board may administer oaths and affirmations. The provisions of subsections (d) and (e) of section 205 with respect to subpoenas shall apply to the Board to the same extent as such provisions apply to the Secretary with respect to title II.

“(ii) The Board is authorized to engage such technical assistance and to receive such information as may be required to carry out its functions, and the Secretary shall, in addition, make available to the Board such secretarial, clerical, and other assistance as the Board may require to carry out its functions.

“(F)(i) Each member of the Board who is not an officer or employee of the Federal Government shall be compensated at a rate equal to the daily equivalent of the annual rate of basic pay prescribed for grade GS-18 of the General Schedule under section 5332 of title 5, United States Code, for each day (including travel time) during which such member is engaged in the performance of the duties of the Board. Each member of the Board who is an officer or employee of the United States shall serve without compensation in addition to that received for service as an officer or employee of the United States.

“(ii) Members of the Board shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Board.”.

(2) EFFECT OF DECISIONS OF BOARD ON PAYMENTS TO HOSPITALS.—Section 1886(d)(8) of such Act (42 U.S.C. 1395ww(d)(8)) is amended—

(A) in subparagraph (C)(i), by striking “subparagraph (B)” each place it appears and inserting “subparagraph (B) or a decision of the Medicare Geographic Classification Review Board or the Secretary under paragraph (10),”, and

(B) in subparagraph (D), by striking “(B) and (C)” each place it appears and inserting “(B) and (C) or a decision of the Medicare Geographic Classification Review Board or the Secretary under paragraph (10),”.

(3) REVISION OF RULES FOR TREATMENT OF RECLASSIFIED HOSPITALS.—Section 1886(d)(8)(C) of such Act is amended to read as follows:

“(C)(i) If the application of subparagraph (B) or a decision of the Medicare Geographic Classification Review Board or the Secretary under paragraph (10), by treating hospitals located in a rural county or counties as being located in an urban area—

“(I) reduces the wage index for that urban area (as applied under this subsection) by 1 percentage point or less, the Secre-

tary, in calculating such wage index under this subsection, shall exclude those hospitals so treated, or

“(II) reduces the wage index for that urban area by more than 1 percentage point (as applied under this subsection), the Secretary shall calculate and apply such wage index under this subsection separately to hospitals located in such urban area (excluding all the hospitals so treated) and to the hospitals so treated (as if each affected rural county were a separate urban area),

“(ii) If the application of subparagraph (B) or a decision of the Medicare Geographic Classification Review Board or the Secretary under paragraph (10), by reclassifying a county from a rural to an urban area or by reclassifying an urban county from one urban area to another urban area.

“(I) reduces the wage index for the urban area within which the county or counties is reclassified by 1 percentage point or less (as applied under this subsection), the Secretary, in calculating such wage index under this subsection, shall exclude those counties so reclassified, or

“(II) reduces the wage index for the urban area within which the county or counties is reclassified by more than 1 percentage point (as applied under this subsection), the Secretary shall calculate and apply such wage index under this subsection separately to hospitals located in such urban area (excluding all the hospitals so reclassified) and to hospitals located in the counties so reclassified (as if each affected county were a separate area).

“(iii) If the application of subparagraph (B) or a decision of the Medicare Geographic Classification Review Board or the Secretary under paragraph (10), by treating hospitals located in a rural county or counties as not being located in the rural area in a State, reduces the wage index for that rural area (as applied under this subsection), the Secretary shall calculate and apply such wage index under this subsection as if the hospitals so treated had not been excluded from calculation of the wage index for that rural area.”.

(4) FLOOR FOR AREA WAGE INDICES.—Section 1886(d)(8)(C) of such Act (as amended by paragraph (3)) is further amended by adding at the end the following new clause:

“(iv) The application of subparagraph (B) or a decision of the Medicare Geographic Classification Review Board or the Secretary under paragraph (10) may not result in the reduction of any county's wage index to a level below the wage index for rural areas in the State in which the county is located.”.

(5) ADDITIONAL PAYMENT RESULTING FROM CORRECTIONS OF ERRONEOUSLY DETERMINED WAGE INDEX.—

(A) IN GENERAL.—If the Secretary of Health and Human Services (hereafter referred to as the “Secretary”) discovers an error with respect to the determination, adjustment, or computation of the area wage index described in section 1886(d)(3)(E) of the Social Security Act and subsequently corrects such error, the Secretary shall make an additional payment under title XVIII of such Act to a hospital affected by such error for inpatient hospital discharges occurring

during the period when the erroneously determined, adjusted, or computed wage index was in effect.

(B) **CONDITIONS FOR ADDITIONAL PAYMENT.**—A hospital is eligible for an additional payment under subparagraph (A) only if—

(i) the error resulted from the submission of erroneous data, except that a hospital is not eligible for such additional payment if it submitted such erroneous data;

(ii) the error was made with respect to the survey of the 1984 wages and wage-related costs of hospitals in the United States conducted under section 1886(d)(4)(E) of the Social Security Act; and

(iii) the correction of the error resulted in an adjustment to the area wage index of not less than 3 percentage points.

(C) **PERIOD OF APPLICABILITY.**—A hospital may not receive an additional payment under subparagraph (A) for discharges occurring after October 1, 1990.

(6) **UPDATES TO WAGE INDEX SURVEY.**—Section 1886(d)(3)(E) of the Social Security Act (42 U.S.C. 1395ww(d)(3)(E)) is amended—

(A) by striking “October 1, 1990 (and at least every 36 months thereafter)” and inserting in lieu thereof “October 1, 1990, and October 1, 1993 (and at least every 12 months thereafter)”, and

(B) by adding at the end the following new sentence: “Any adjustments or updates made under this subparagraph for a fiscal year (beginning with fiscal year 1991) shall be made in a manner that assures that the aggregate payments under this subsection in the fiscal year are not greater or less than those that would have been made in the year without such adjustment.”.

(7) **EFFECTIVE DATE.**—The amendments made by paragraphs (3) and (4) shall apply to discharges occurring on or after April 1, 1990.

(i) **LEGISLATIVE PROPOSAL ELIMINATING SEPARATE AVERAGE STANDARDIZED AMOUNTS.**—

(1) **IN GENERAL.**—The Secretary of Health and Human Services (hereafter referred to as the “Secretary”) shall design a legislative proposal eliminating the system of determining separate average standardized amounts for subsection (d) hospitals (as defined in section 1886(d)(1)(B) of the Social Security Act) classified as being located in large urban, other urban, or rural areas under section 1886(d)(2)(D) of such Act, and shall include in such proposal the following:

(A) A transition period beginning in fiscal year 1992 during which a single rate for determining payment to hospitals in all areas shall be phased in with such single rate to be completely in effect by fiscal year 1995.

(B) Recommendations, where appropriate, for modifying or maintaining additional payments or adjustments made under title XVIII of the Social Security Act for teaching hospitals, rural referral centers, sole community hospitals,

disproportionate share hospitals, and outlier cases, and for creating additional payments or adjustments where deemed appropriate by the Secretary.

(C) Recommendations with respect to recalculating standardized amounts to reflect information from more recent cost reporting periods.

(5) Recommendations, where appropriate, for modifying reimbursement for hospitals that are not subsection (d) hospitals under title XVIII of such Act.

(6) A recommendation for a methodology to reflect the severity of illness of different patients within the same diagnosis related group (as determined in section 1886(d)(4)(B) of such Act).

(2) REPORT TO CONGRESS AND PROPAC.—(A) Not later than October 1, 1990, the Secretary shall submit the proposal described in paragraph (1) and an accompanying analysis of the impact of the proposed elimination of separate average standardized amounts on various categories of hospitals to Congress and the Prospective Payment Assessment Commission.

(B) Not later than February 1, 1991, the Prospective Payment Assessment Commission and the Director of the Congressional Budget Office shall each prepare and submit to Congress a report analyzing the legislative proposal submitted under subparagraph (A), and shall include in such report an analysis of the probable impact of such legislation on hospitals participating in the medicare program.

(j) PROPAC STUDY OF PAYMENTS TO RURAL SOLE COMMUNITY HOSPITALS AND SMALL RURAL HOSPITALS.—

(1) STUDY.—The Prospective Payment Assessment Commission (hereafter referred to as the “Commission”) shall conduct a study of the feasibility and desirability of—

(A) using a cost-based reimbursement system to determine the amount of payments to be made under the medicare program to small rural hospitals and rural sole community hospitals for the operating costs of inpatient hospital services;

(B) developing and applying alternative definitions of market share for use in determining the eligibility of hospitals for classification as sole community hospitals under section 1886(d)(5) of the Social Security Act; and

(C) developing and applying a method for accounting for decreases in the number of inpatients served in determining payment to small rural hospitals under section 1886(d) of the Social Security Act or the operating costs of inpatient hospital services.

(2) REPORT.—By not later than May 1, 1990, the Commission shall submit a report to Congress on the study conducted under paragraph (1).

SEC. 6004. PPS-EXEMPT HOSPITALS.

(a) EXEMPTION OF CANCER HOSPITALS FROM PROSPECTIVE PAYMENT SYSTEM.—

(1) IN GENERAL.—Section 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)) is amended—

(A) in clause (iii), by striking “or”;

(B) in clause (iv), by striking the semicolon at the end and inserting “, or”; and

(C) by inserting after clause (iv) the following new clause:

“(v) a hospital that the Secretary has classified, at any time on or before December 31, 1990, (or, in the case of a hospital that, as of the date of the enactment of this clause, is located in a State operating a demonstration project under section 1814(b), on or before December 31, 1991) for purposes of applying exceptions and adjustments to payment amounts under this subsection, as a hospital involved extensively in treatment for or research on cancer, ;”.

(2) **CONFORMING AMENDMENT.**—Section 1886(d)(5)(H) of such Act (as redesignated by section 10102(f)(1)(B)) is amended by striking “(including” and all that follows through “cancer”).

(3) **EFFECTIVE DATE.**—The amendments made by this subsection shall apply with respect to cost reporting periods beginning on or after October 1, 1989, except that—

(A) in the case of a hospital classified by the Secretary of Health and Human Services as a hospital involved extensively in treatment for or research on cancer under section 1886(d)(5)(H) of the Social Security Act (as redesignated by section 6003(e)(1)(A)) after the date of the enactment of this Act, such amendments shall apply with respect to cost reporting periods beginning on or after the date of such classification,

(B) in the case of a hospital that is not described in subparagraph (A), such amendments shall apply with respect to portions of cost reporting periods or discharges occurring during and after fiscal year 1987 for purposes of section 1886(g) of the Social Security Act, and

(C) such amendments shall take effect 30 days after the date of the enactment of this Act for purposes of determining the eligibility of a hospital to receive periodic interim payments under section 1815(e)(2) of the Social Security Act.

(b) REBASING FOR CANCER HOSPITALS.—

(1) **IN GENERAL.**—Section 1886(b)(3) of such Act (42 U.S.C. 1395ww(b)(3)), as amended by subsections (e)(1)(B) and (f)(2) of section 6003, is further amended—

(A) in subparagraph (A), by striking “(C) and (D)” and inserting “(C), (D), and (E)”,

(B) in subparagraph (B)(ii), by striking “For purposes of subparagraph (A)” and inserting “For purposes of subparagraphs (A) and (E)”, and

(C) by adding at the end the following new subparagraph:

“(E) In the case of a hospital described in clause (v) of subsection (d)(1)(B), the term ‘target amount’ means—

“(i) with respect to the first 12-month cost reporting period in which this subparagraph is applied to the hospital—

“(I) the allowable operating costs of inpatient hospital services (as defined in subsection (a)(4)) recognized under this title for the hospital for the 12-month cost reporting period (in this subparagraph referred to as the ‘base cost re-

porting period') preceding the first cost reporting period for which this subsection was in effect with respect to such hospital, increased (in a compounded manner) by—

"(II) the sum of the applicable percentage increases applied to such hospital under this paragraph for cost reporting periods after the base cost reporting period and up to and including such first 12-month cost reporting period, or

"(ii) with respect to a later cost reporting period, the target amount for the preceding 12-month cost reporting period, increased by the applicable percentage increase under subparagraph (B)(ii) for that later cost reporting period.

There shall be substituted for the base cost reporting period described in clause (i) a hospital's cost reporting period (if any) beginning during fiscal year 1987 if such substitution results in an increase in the target amount for the hospital."

(2) *EFFECTIVE DATE.*—The amendments made by paragraph (1) shall apply with respect to cost reporting periods beginning on or after April 1, 1989.

SEC. 6005. PAYMENTS FOR HOSPICE CARE.

(a) *INCREASE IN CURRENT RATES.*—Section 1814(i)(1) of the Social Security Act (42 U.S.C. 1395f(i)(1)) is amended—

(A) in subparagraph (A), by inserting "and except as otherwise provided in this paragraph" after "1813(a)(4)", and

(B) by striking subparagraph (C) and inserting the following:

"(C)(i) With respect to routine home care and other services included in hospice care furnished during fiscal year 1990, the payment rates for such care and services shall be 120 percent of such rates in effect as of September 30, 1989.

"(ii) With respect to routine home care and other services included in hospice care furnished during a subsequent fiscal year, the payment rates for such care and services shall be the payment rates in effect under this subparagraph during the previous fiscal year increased by the market basket percentage increase (as defined in section 1886(b)(3)(B)(iii)) otherwise applicable to discharges occurring in the fiscal year."

(b) *REQUIREMENT OF CERTIFICATION OF TERMINAL ILLNESS FOR HOSPICE CARE MODIFIED.*—Section 1814(a)(7)(A)(i) of the Social Security Act (42 U.S.C. 1395f(a)(7)(A)(i)) is amended by striking "certify," and all that follows through "initiated," and inserting the following: "certify in writing, not later than 2 days after hospice care is initiated (or, if each certify verbally not later than 2 days after hospice care is initiated, not later than 8 days after such care is initiated),".

(c) *EFFECTIVE DATE.*—The amendments made by subsection (a) shall become effective with respect to care and services furnished on or after January 1, 1990.

Subpart B—Technical and Miscellaneous Provisions

SEC. 6011. PASS THROUGH PAYMENT FOR HEMOPHILIA INPATIENTS.

(a) **PASS THROUGH PAYMENT FOR HEMOPHILIA INPATIENTS.**—The second sentence of section 1886(a)(4) of the Social Security Act (42 U.S.C. 1395ww(d)(4)) is amended—

(1) by striking “or,”; and

(2) by striking “October 1, 1987)” and inserting “October 1, 1987), or costs with respect to administering blood clotting factors to individuals with hemophilia”.

(b) **DETERMINING PAYMENT AMOUNT.**—The Secretary of Health and Human Services shall determine the amount of payment made to hospitals under part A of title XVIII of the Social Security Act for the costs of administering blood clotting factors to individuals with hemophilia by multiplying a predetermined price per unit of blood clotting factor (determined in consultation with the Prospective Payment Assessment Commission) by the number of units provided to the individual.

(c) **RECOMMENDATIONS ON PAYMENTS.**—The Prospective Payment Assessment Commission and the Health Care Financing Administration shall develop recommendations with respect to payments to hospitals under part A of title XVIII of the Social Security Act for the costs of administering blood clotting factors to individuals with hemophilia, and shall submit such recommendations to Congress not later than 18 months after the date of enactment of this Act.

(d) **EFFECTIVE DATE.**—The amendment made by paragraph (1) shall apply with respect to items furnished 6 months after the date of enactment of this Act and shall expire 2 years after the date of enactment of this Act.

SEC. 6012. MEDICARE BUY-IN FOR CONTINUED BENEFITS FOR DISABLED INDIVIDUALS.

(a) **IN GENERAL.**—Title XVIII of the Social Security Act is amended—

(1) in the heading of section 1818, by inserting “ELDERLY” after “UNINSURED”; and

(2) by inserting after section 1818 the following new section:

“HOSPITAL INSURANCE BENEFITS FOR DISABLED INDIVIDUALS WHO HAVE EXHAUSTED OTHER ENTITLEMENT

“SEC. 1818A. (a) Every individual who—

“(1) has not attained the age of 65;

“(2)(A) has been entitled to benefits under this part under section 226(b), and

“(B)(i) continues to have the disabling physical or mental impairment on the basis of which the individual was found to be under a disability or to be a disabled qualified railroad retirement beneficiary, or (ii) is blind (within the meaning of section 216(i)(1)), but

“(C) whose entitlement under section 226(b) ends due solely to the individual having earnings that exceed the SGA amount (as defined in section 226(h)(6)(C)); and

“(3) is not otherwise entitled to benefits under this part,

shall be eligible to enroll in the insurance program established by this part.

“(b)(1) An individual may enroll under this section only in such manner and form as may be prescribed in regulations, and only during an enrollment period prescribed in or under this section.

“(2) The individual’s initial enrollment period shall begin with the month in which the individual receives notice that the individual’s entitlement to benefits under section 226(b) will end due solely to the individual having earnings that exceed the SGA amount (as defined in section 226(h)(6)(C)) and shall end 7 months later.

“(3) There shall be a general enrollment period during the period beginning on January 1 and ending on March 31 of each year (beginning with 1990).

“(c)(1) The period (in this subsection referred to as a ‘coverage period’) during which an individual is entitled to benefits under the insurance program under this part shall begin on whichever of the following is the latest:

“(A) In the case of an individual who enrolls under subsection (b)(2) before the month in which the individual first satisfies subsection (a), the first day of such month.

“(B) In the case of an individual who enrolls under subsection (b)(2) in the month in which he first satisfies subsection (a), the first day of the month following the month in which he so enrolls.

“(C) In the case of an individual who enrolls under subsection (b)(2) in the month following the month in which the individual first satisfies subsection (a), the first day of the second month following the month in which he so enrolls.

“(D) In the case of an individual who enrolls under subsection (b)(2) more than one month following the month in which the individual first satisfies subsection (a), the first day of the third month following the month in which he so enrolls.

“(E) In the case of an individual who enrolls under subsection (b)(3), the July 1 following the month in which the individual so enrolls.

“(2) An individual’s coverage period under this section shall continue until the individual’s enrollment is terminated as follows:

“(A) As of the month following the month in which the Secretary provides notice to the individual that the individual no longer meets the condition described in subsection (a)(2)(B).

“(B) As of the month following the month in which the individual files notice that the individual no longer wishes to participate in the insurance program established by this part.

“(C) As of the month before the first month in which the individual becomes eligible for hospital insurance benefits under section 226(a) or 226A.

“(D) As of a date, determined under regulations of the Secretary, for nonpayment of premiums.

The regulations under subparagraph (D) may provide a grace period of not longer than 90 days, which may be extended to not to exceed 180 days in any case where the Secretary determines that there was good cause for failure to pay the overdue premiums within such 90-day period. Termination of coverage under this section shall result

in simultaneous termination of any coverage affected under any other part of this title.

“(3) The provisions of subsections (h) and (i) of section 1837 apply to enrollment and nonenrollment under this section in the same manner as they apply to enrollment and nonenrollment and special enrollment periods under section 1818.

“(d)(1)(A) Premiums shall be paid to the Secretary at such times, and in such manner, as the Secretary shall by regulations prescribe, and shall be deposited in the Treasury to the credit of the Federal Hospital Insurance Trust Fund.

“(B)(i) Subject to clause (ii), such premiums shall be payable for the period commencing with the first month of an individual’s coverage period and ending with the month in which the individual dies or, if earlier, in which the individual’s coverage period terminates.

“(ii) Such premiums shall not be payable for any month in which the individual is eligible for benefits under this part pursuant to section 226(b).

“(C) For purposes of applying section 1839(g) of this title and section 59B(f)(1)(B)(i) of the Internal Revenue Code of 1986, any reference to section 1818 shall be deemed to include a reference to this section.

“(2) The provisions of subsections (d) through (f) of section 1818 (relating to premiums) shall apply to individuals enrolled under this section in the same manner as they apply to individuals enrolled under that section.”.

(b) **EFFECTIVE DATE.**—The amendments made by this section shall take effect on the date of the enactment of this Act, but shall not apply so as to provide for coverage under part A of title XVIII of the Social Security Act for any month before July 1990.

SEC. 6013. BUY-IN UNDER PART A FOR QUALIFIED MEDICARE BENEFICIARIES.

(a) **IN GENERAL.**—Section 1818 of the Social Security Act (42 U.S.C. 1395i-2) is amended by adding at the end the following:

“(g)(1) The Secretary shall, at the request of a State made after 1989, enter into a modification of an agreement entered into with the State pursuant to section 1843(a) under which the agreement provides for enrollment in the program established by this part of qualified medicare beneficiaries (as defined in section 1905(p)(1)).

“(2)(A) Except as provided in subparagraph (B), the provisions of subsections (c), (d), (e), and (f) of section 1843 shall apply to qualified medicare beneficiaries enrolled, pursuant to such agreement, in the program established by this part in the same manner and to the same extent as they apply to qualified medicare beneficiaries enrolled, pursuant to such agreement, in part B.

“(B) For purposes of this subsection, section 1843(d)(1) shall be applied by substituting ‘section 1818’ for ‘section 1839’ and ‘subsection (c) (with reference to subsection (b) of section 1839’ for ‘subsection (b).’.”.

(b) **CONFORMING AMENDMENT.**—Section 1843 of such Act (42 U.S.C. 1395v) is amended by adding at the end the following:

“(i) For provisions relating to enrollment of qualified medicare beneficiaries under part A, see section 1818(g).”.

(c) **EFFECTIVE DATE.**—The amendments made by this section shall become effective January 1, 1990.

SEC. 6014. PROPAC STUDY ON MEDICARE DEPENDENT HOSPITALS.

(a) **STUDY.**—The Prospective Payment Assessment Commission shall conduct a study of the appropriateness of making an adjustment to the methodology for determining the amount of payment to hospitals for which individuals entitled to benefits under part A of title XVIII of the Social Security Act represent a high proportion of discharges.

(b) **REPORT.**—Not later than June 1, 1990, the Commission shall include a report on the study conducted under subsection (a) in its annual report submitted to Congress.

SEC. 6015. PROVISIONS RELATING TO TARGET AMOUNT ADJUSTMENTS.

(a) **INCLUDING NEW BASE PERIOD IN TARGET ADJUSTMENTS.**—Section 1886(b)(4)(A) of the Social Security Act (42 U.S.C. 1395ww(b)(4)(A)) is amended by striking “deems appropriate,” and inserting in lieu thereof “deems appropriate, including the assignment of a new base period which is more representative, as determined by the Secretary, of the reasonable and necessary cost of inpatient services and”.

(b) **PUBLICATION OF INSTRUCTIONS RELATING TO EXCEPTIONS AND ADJUSTMENTS IN TARGET AMOUNTS.**—By not later than 180 days after the date of enactment of this Act, the Secretary of Health and Human Services shall publish instructions specifying the application process to be used in providing exceptions and adjustments under section 1886(b)(4)(A) of the Social Security Act.

(c) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall become effective with respect to cost reporting periods beginning on or after April 1, 1990.

SEC. 6016. STUDY OF METHODS TO COMPENSATE HOSPICES FOR HIGH-COST CARE.

(a) **STUDY.**—The Secretary of Health and Human Services shall—

(1) conduct a study of high-cost hospice care provided to medicare beneficiaries under the medicare program, and evaluate the ability of hospice programs participating in the medicare program to provide such high-cost care to such patients; and

(2) based on such study, develop methods to compensate such programs for providing such high-cost care.

(b) **REPORT TO CONGRESS.**—Not later than April 1, 1991, the Secretary shall submit a report to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate on the study conducted under subsection (a) and shall include in the report any recommendations developed by the Secretary to compensate hospice programs for providing high-cost hospice care to medicare beneficiaries.

SEC. 6017. PROHIBITION ON NURSING HOME BALANCE BILLING.

Section 1866(a)(2)(B) of the Social Security Act (42 U.S.C. 1395ww(a)(2)(B)) is amended—

(1) in clause (i), by striking “(i)”; and

(2) by striking clause (ii).

SEC. 6018. HOSPITAL ANTI-DUMPING PROVISIONS.

(a) **HOSPITAL OBLIGATIONS WITH RESPECT TO TREATMENT OF EMERGENCY MEDICAL CONDITIONS AND INDIGENT CARE.**—Section 1866(a)(1) of the Social Security Act (42 U.S.C. 1395cc(a)(1)) is amended—

(1) by amending subparagraph (I) to read as follows:

“(I) in the case of a hospital or rural primary care hospital—

“(i) to adopt and enforce a policy to ensure compliance with the requirements of section 1867,

“(ii) to maintain medical and other records related to individuals transferred to or from the hospital for a period of five years from the date of the transfer, and

“(iii) to maintain a list of physicians who are on call for duty after the initial examination to provide treatment necessary to stabilize an individual with an emergency medical condition;”; and

(2) in subparagraph (N)—

(A) by striking “and” at the end of clause (i),

(B) by striking “and” at the end of clause (ii), and

(C) by adding at the end the following new clauses:

“(iii) to post conspicuously in any emergency department a sign (in a form specified by the Secretary) specifying rights of individuals under section 1867 with respect to examination and treatment for emergency medical conditions and women in labor, and

“(iv) to post conspicuously (in a form specified by the Secretary) information indicating whether or not the hospital participates in the medicaid program under a State plan approved under title XIX, and”.

(b) **EFFECTIVE DATE.**—The amendments made by subsection (a) shall take effect on the first day of the first month that begins more than 180 days after the date of the enactment of this Act, without regard to whether regulations to carry out such amendments have been promulgated by such date.

SEC. 6019. RELEASE AND USE OF HOSPITAL ACCREDITATION SURVEYS.

(a) **REQUIRING ALL INSTITUTIONS AND JCAHO TO RELEASE SURVEYS TO SECRETARY.**—Section 1865(a)(2) of the Social Security Act (42 U.S.C. 1395bb(a)(2)) is amended—

(1) by striking “(2) such institution” and inserting “(2)(A) such institution”;

(2) by striking “(if it is included within a survey described in section 1864(c))”;

(3) by striking the comma at the end and inserting the following: “, together with any other information directly related to the survey as the Secretary may require (including corrective action plans),”; and

(4) by adding at the end the following new subparagraph:

“(B) such Commission releases such a copy and any such information to the Secretary.”.

(b) **AUTHORIZING SECRETARY TO RELEASE CERTAIN INFORMATION.**—Section 1865(a) of such Act is further amended by striking the period at the end of the last sentence and inserting the follow-

ing: “, except that the Secretary may disclose such a survey and information related to such a survey to the extent such survey and information relate to an enforcement action taken by the Secretary.”.

(c) **PERMITTING SECRETARY TO WITHDRAW HOSPITAL'S STATUS BASED UPON INFORMATION OTHER THAN SURVEYS.**—Section 1865(b) of such Act is amended by striking “following a survey made pursuant to section 1864(c)”.

(d) **EFFECTIVE DATE.**—(1) Except as provided in paragraph (2), the amendments made by this section shall take effect on the date of the enactment of this Act.

(2) The amendments made by subsection (a) shall take effect 6 months after the date of the enactment of this Act.

SEC. 6020. INTERMEDIATE SANCTIONS FOR PSYCHIATRIC HOSPITALS.

Section 1866 of the Social Security Act (42 U.S.C. 1395cc) is amended by adding at the end the following new subsection:

“(i)(1) If the Secretary determines that a psychiatric hospital which has an agreement in effect under this section no longer meets the requirements for a psychiatric hospital under this title and further finds that the hospital's deficiencies—

“(A) immediately jeopardize the health and safety of its patients, the Secretary shall terminate such agreement; or

“(B) do not immediately jeopardize the health and safety of its patients, the Secretary may terminate such agreement, or provide that no payment will be made under this title with respect to any individual admitted to such hospital after the effective date of the finding, or both.

“(2) If a psychiatric hospital, found to have deficiencies described in paragraph (1)(B), has not complied with the requirements of this title—

“(A) within 3 months after the date the hospital is found to be out of compliance with such requirements, the Secretary shall provide that no payment will be made under this title with respect to any individual admitted to such hospital after the end of such 3-month period, or

“(B) within 6 months after the date the hospital is found to be out of compliance with such requirements, no payment may be made under this title with respect to any individual in the hospital until the Secretary finds that the hospital is in compliance with the requirements of this title.”.

SEC. 6021. ELIGIBILITY OF MERGED OR CONSOLIDATED HOSPITALS FOR PERIODIC INTERIM PAYMENTS.

(a) **IN GENERAL.**—Section 1815(e) of the Social Security Act (42 U.S.C. 1395g(e)) is amended by adding at the end the following new paragraph:

“(4) A hospital created by the merger or consolidation of 2 or more hospitals or hospital campuses shall be eligible to receive periodic interim payment on the basis described in paragraph (1)(B) if—

“(A) at least one of the hospitals or campuses received periodic interim payment on such basis prior to the merger or consolidation; and

“(B) the merging or consolidating hospitals or campuses would each meet the requirement of paragraph (1)(B)(i) if such

hospitals or campuses were treated as independent hospitals for purposes of this title."

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to payments made for discharges occurring on or after the expiration of the 30-day period that begins on the date of the enactment of this Act, regardless of the date of the merger or consolidation involved.

SEC. 6022. EXTENSION OF WAIVER FOR FINGER LAKES AREA HOSPITAL CORPORATION.

Section 1886(c)(4) of the Social Security Act (42 U.S.C. 1395ww(c)(4)) is amended in the second sentence by striking "the aggregate payment or payments" and all that follows and inserting "the aggregate rate of increase from October 1, 1984, to the most recent date for which annual data are available."

SEC. 6023. CLARIFICATION OF CONTINUATION OF AUGUST 1987 HOSPITAL BAD DEBT RECOGNITION POLICY.

(a) IN GENERAL.—Section 4008(c) of the Omnibus Budget Reconciliation Act of 1987 is amended by adding at the end the following: "The Secretary may not require a hospital to change its bad debt collection policy if a fiscal intermediary, in accordance with the rules in effect as of August 1, 1987, with respect to criteria for indigency determination procedures, record keeping, and determining whether to refer a claim to an external collection agency, has accepted such policy before that date, and the Secretary may not collect from the hospital on the basis of an expectation of a change in the hospital's collection policy."

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect as if included in the enactment of the Omnibus Budget Reconciliation Act of 1987.

SEC. 6024. USE OF MORE RECENT DATA REGARDING ROUTINE SERVICE COSTS OF SKILLED NURSING FACILITIES.

The Secretary of Health and Human Services shall determine mean per diem routine service costs for freestanding and hospital based skilled nursing facilities under section 1888(a) of the Social Security Act for cost reporting periods beginning on or after October 1, 1989, in accordance with regulations published by the Secretary that require the use of cost reports submitted by skilled nursing facilities for cost reporting periods beginning not earlier than October 1, 1985.

SEC. 6025. PERMITTING DENTIST TO SERVE AS HOSPITAL MEDICAL DIRECTOR.

Notwithstanding the requirement that the responsibility for organization and conduct of the medical staff of an institution be assigned only to a doctor of medicine or osteopathy in order for the institution to participate as a hospital under the medicare program, an institution that has a doctor of dental surgery or of dental medicine serving as its medical director shall be considered to meet such requirement if the laws of the State in which the institution is located permit a doctor of dental surgery or of dental medicine to serve as the medical staff director of a hospital.

SEC. 6026. GAO STUDY OF HOSPITAL-BASED AND FREESTANDING SKILLED NURSING FACILITIES.

(a) **STUDY.**—The Comptroller General shall conduct a study to assess the differences in costs and case-mix between hospital-based and freestanding skilled nursing facilities participating in the medicare program.

(b) **REPORT.**—By not later than June 1, 1990, the Comptroller General shall submit a report to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate on the study conducted under paragraph (1) and shall include in the report any recommendations, including recommendations regarding the payment differential between hospital-based and freestanding skilled nursing facilities, the Comptroller General considers appropriate.

SEC. 6027. MASSACHUSETTS MEDICARE REPAYMENT.

The Secretary of Health and Human Services may not, on or after the date of the enactment of this Act and before May 1, 1990, recoup from, or otherwise reduce payments to, hospitals in the State of Massachusetts because of alleged overpayments to such hospitals under part A of title XVIII of the Social Security Act which occurred during the period of the statewide hospital reimbursement demonstration project conducted in that State between October 1, 1982, and June 30, 1986, under section 402 of the Social Security Amendments of 1967 and section 222 of the Social Security Amendments of 1972. Interest shall not accrue on any such alleged overpayments during the period beginning on the date of the enactment of this Act and ending on May 1, 1990.

SEC. 6028. ALLOWING CERTIFICATIONS AND RECERTIFICATIONS BY NURSE PRACTITIONERS AND CLINICAL NURSE SPECIALISTS FOR CERTAIN SERVICES.

Section 1814(a) of the Social Security Act (42 U.S.C. 1395f(a)) is amended—

(1) in paragraph (2) by striking “(2) a physician” and inserting in lieu thereof “(2) a physician, or, in the case of services described in subparagraph (B), a physician, or a nurse practitioner or clinical nurse specialist who does not have a direct or indirect employment relationship with the facility but is working in collaboration with a physician,”; and

(2) in the matter following the final paragraph by striking “a physician makes” and inserting in lieu thereof “a physician, nurse practitioner, or clinical nurse specialist (as the case may be) makes”.

PART 2—PROVISIONS RELATING TO PART B

Subpart A—General Provisions

SEC. 6101. EXTENSION OF REDUCTIONS UNDER SEQUESTER ORDER.

Notwithstanding any other provision of law (including any other provision of this Act, other than section 6201), the reductions in the amount of payments required under title XVIII of the Social Security Act made by the final sequester order issued by the President on October 16, 1989, pursuant to section 252(b) of the Balanced Budget

and *Emergency Deficit Control Act of 1985* shall continue to be effective (as provided by sections 252(a)(4)(B) and 256(d)(2) of such Act) through March 31, 1990, with respect to payments for items and services under part B of such title.

SEC. 6102. PHYSICIAN PAYMENT REFORM.

(a) *IN GENERAL.*—Part B of title XVIII of the Social Security Act is amended by adding at the end the following new section:

“PAYMENT FOR PHYSICIANS’ SERVICES

“SEC. 1848. (a) PAYMENT BASED ON FEE SCHEDULE.—

“(1) *IN GENERAL.*—Effective for all physicians’ services (as defined in subsection (j)(3)) furnished under this part during a year (beginning with 1992) for which payment is otherwise made on the basis of a reasonable charge or on the basis of a fee schedule under section 1834(b), payment under this part shall instead be based on the lesser of—

“(A) the actual charge for the service, or

“(B) subject to the succeeding provisions of this subsection, the amount determined under the fee schedule established under subsection (b) for services furnished during that year (in this subsection referred to as the ‘fee schedule amount’).

“(2) TRANSITION TO FULL FEE SCHEDULE.—

“(A) *LIMITING REDUCTIONS AND INCREASES TO 15 PERCENT IN 1992.—*

“(i) *LIMIT ON INCREASE.*—In the case of a service in a fee schedule area (as defined in subsection (j)(2)) for which the adjusted historical payment basis (as defined in subparagraph (D)) is less than 85 percent of the fee schedule amount for services furnished in 1992, there shall be substituted for the fee schedule amount an amount equal to the adjusted historical payment basis plus 15 percent of the fee schedule amount otherwise established (without regard to this paragraph).

“(ii) *LIMIT IN REDUCTION.*—In the case of a service in a fee schedule area for which the adjusted historical payment basis exceeds 115 percent of the fee schedule amount for services furnished in 1992, there shall be substituted for the fee schedule amount an amount equal to the adjusted historical payment basis minus 15 percent of the fee schedule amount otherwise established (without regard to this paragraph).

“(B) *SPECIAL RULE FOR 1993, 1994, AND 1995.*—If a physicians’ service in a fee schedule area is subject to the provisions of subparagraph (A) in 1992, for physicians’ services furnished in the area—

“(i) during 1993, there shall be substituted for the fee schedule amount an amount equal to the sum of—

“(I) 75 percent of the fee schedule amount determined under subparagraph (A), adjusted by the update established under subsection (d)(3) for 1993, and

“(II) 25 percent of the fee schedule amount determined under paragraph (1) for 1993 without regard to this paragraph;

“(ii) during 1994, there shall be substituted for the fee schedule amount an amount equal to the sum of—

“(I) 67 percent of the fee schedule amount determined under clause (i), adjusted by the update established under subsection (d)(3) for 1994, and

“(II) 33 percent of the fee schedule amount determined under paragraph (1) for 1994 without regard to this paragraph; and

“(iii) during 1995, there shall be substituted for the fee schedule amount an amount equal to the sum of—

“(I) 50 percent of the fee schedule amount determined under clause (ii) adjusted by the update established under subsection (d)(3) for 1995, and

“(II) 50 percent of the fee schedule amount determined under paragraph (1) for 1995 without regard to this paragraph.

“(C) SPECIAL RULE FOR ANESTHESIA SERVICES.—With respect to physicians’ services which are anesthesia services, the Secretary shall provide for a transition in the same manner as a transition is provided for other services under subparagraph (B).

“(D) ADJUSTED HISTORICAL PAYMENT BASIS DEFINED.—

“(i) IN GENERAL.—In this paragraph, the term ‘adjusted historical payment basis’ means, with respect to a physicians’ service furnished in a fee schedule area, the weighted average prevailing charge applied in the area for the service in 1991 (as determined by the Secretary without regard to physician specialty and as adjusted to reflect payments for services with customary charges below the prevailing charge or other payment limitations imposed by law or regulation) adjusted by the update established under subsection (d)(3) for 1992.

“(ii) APPLICATION TO RADIOLOGY SERVICES.—In applying clause (i) in the case of physicians’ services which are radiology services (including radiologist services, as defined in section 1834(b)(6)), there shall be substituted for the weighted average prevailing charge the amount provided under the fee schedule established for the service for the fee schedule area under section 1834(b).

“(3) INCENTIVES FOR PARTICIPATING PHYSICIANS.—In applying paragraph (1)(B) in the case of a nonparticipating physician, the fee schedule amount shall be 95 percent of such amount otherwise applied under this subsection (without regard to this paragraph).

“(b) ESTABLISHMENT OF FEE SCHEDULES.—

“(1) IN GENERAL.—Before January 1 of each year beginning with 1992, the Secretary shall establish, by regulation, fee schedules that establish payment amounts for all physicians’ services furnished in all fee schedule areas (as defined in subsection (j)(2)) for the year. Except as provided in paragraph (2),

each such payment amount for a service shall be equal to the product of—

“(A) the relative value for service (as determined in subsection (c)(2)(B)),

“(B) the conversion factor (established under subsection (d)) for the year, and

“(C) the geographic adjustment factor (established under subsection (e)(2)) for the service for the fee schedule area.

“(2) TREATMENT OF RADIOLOGY SERVICES AND ANESTHESIA SERVICES.—

“(A) RADIOLOGY SERVICES.—With respect to radiology services (including radiologist services, as defined in section 1834(b)(6)), the Secretary shall base the relative values on the relative value scale developed under section 1834(b)(1)(A), with appropriate modifications of the relative values to assure that the relative values established for radiology services which are similar or related to other physicians' services are consistent with the relative values established for those similar or related services.

“(B) ANESTHESIA SERVICES.—In establishing the fee schedule for anesthesia services for which a relative value guide has been established under section 4048(b) of the Omnibus Budget Reconciliation Act of 1987, the Secretary shall use, to the extent practicable, such relative value guide, with appropriate adjustment of the conversion factor, in a manner to assure that the fee schedule amounts for anesthesia services are consistent with the fee schedule amounts for other services determined by the Secretary to be of comparable value. In applying the previous sentence, the Secretary shall adjust the conversion factor by geographic adjustment factors in the same manner as such adjustment is made under paragraph (1)(C).

“(C) CONSULTATION.—The Secretary shall consult with the Physician Payment Review Commission and organizations representing physicians or suppliers who furnish radiology services and anesthesia services in applying subparagraphs (A) and (B).

“(c) DETERMINATION OF RELATIVE VALUES FOR PHYSICIANS' SERVICES.—

“(1) DIVISION OF PHYSICIANS' SERVICES INTO COMPONENTS.—In this section, with respect to a physicians' service:

“(A) WORK COMPONENT DEFINED.—The term ‘work component’ means the portion of the resources used in furnishing the service that reflects physician time and intensity in furnishing the service. Such portion shall—

“(i) include activities before and after direct patient contact, and

“(ii) be defined, with respect to surgical procedures, to reflect a global definition including pre-operative and post-operative physicians' services.

“(B) PRACTICE EXPENSE COMPONENT DEFINED.—The term ‘practice expense component’ means the portion of the resources used in furnishing the service that reflects the general categories of expenses (such as office rent and wages of

personnel, but excluding malpractice expenses) comprising practice expenses. In this subparagraph, the term 'practice expenses' includes all expenses for furnishing physicians' services, excluding malpractice expenses, physician compensation, and other physician fringe benefits.

"(C) **MALPRACTICE COMPONENT DEFINED.**—The term 'malpractice component' means the portion of the resources used in furnishing the service that reflects malpractice expenses in furnishing the service.

"(2) **DETERMINATION OF RELATIVE VALUES.**—

"(A) **IN GENERAL.**—

"(i) **COMBINATION OF UNITS FOR COMPONENTS.**—The Secretary shall develop a methodology for combining the work, practice expense, and malpractice relative value units, determined under subparagraph (C), for each service in a manner to produce a single relative value for that service.

"(ii) **EXTRAPOLATION.**—The Secretary may use extrapolation and other techniques to determine the number of relative value units for physicians' services for which specific data are not available and shall take into account recommendations of the Physician Payment Review Commission and the results of consultations with organizations representing physicians who provide such services.

"(B) **PERIODIC REVIEW AND ADJUSTMENTS IN RELATIVE VALUES.**—

"(i) **PERIODIC REVIEW.**—The Secretary, not less often than every 5 years, shall review the relative values established under this paragraph for all physicians' services.

"(ii) **ADJUSTMENTS.**—

"(I) **IN GENERAL.**—The Secretary shall, to the extent the Secretary determines to be necessary and subject to subclause (II), adjust the number of such units to take into account changes in medical practice, coding changes, new data on relative value components, or the addition of new procedures. The Secretary shall publish an explanation of the basis for such adjustments.

"(II) **LIMITATION ON ANNUAL ADJUSTMENTS.**—The adjustments under subclause (I) for a year may not cause the amount of expenditures under this part for the year to differ by more than \$20,000,000 from the amount of expenditures under this part that would have been made if such adjustments had not been made.

"(iii) **CONSULTATION.**—The Secretary, in making adjustments under clause (ii), shall consult with the Physician Payment Review Commission and organizations representing physicians.

"(C) **COMPUTATION OF RELATIVE VALUE UNITS FOR COMPONENTS.**—For purposes of this section for each physicians' service—

“(i) WORK RELATIVE VALUE UNITS.—The Secretary shall determine a number of work relative value units for the service based on the relative resources incorporating physician time and intensity required in furnishing the service.

“(ii) PRACTICE EXPENSE RELATIVE VALUE UNITS.—The Secretary shall determine a number of practice expense relative value units equal to the product of—

“(I) the base allowed charges (as defined in subparagraph (D)) for the service, and

“(II) the practice expense percentage for the service (as determined under paragraph (3)(A)).

“(iii) MALPRACTICE RELATIVE VALUE UNITS.—The Secretary shall determine a number of malpractice relative value units equal to the product of—

“(I) the base allowed charges (as defined in subparagraph (D)) for the service, and

“(II) the malpractice percentage for the service (as determined under paragraph (3)(A)).

“(D) BASE ALLOWED CHARGES DEFINED.—In this paragraph, the term ‘base allowed charges’ means, with respect to a physician’s service, the national average allowed charges for the service under this part for services furnished during 1991, as estimated by the Secretary using the most recent data available.

“(3) COMPONENT PERCENTAGES.—For purposes of paragraph (2), the Secretary shall determine a work percentage, a practice expense percentage, and a malpractice percentage for each physician’s service as follows:

“(A) DIVISION OF SERVICES BY SPECIALTY.—For each physician’s service or class of physicians’ services, the Secretary shall determine the average percentage of each such service or class of services that is performed, nationwide, under this part by physicians in each of the different physician specialties (as identified by the Secretary).

“(B) DIVISION OF SPECIALTY BY COMPONENT.—The Secretary shall determine the average percentage division of resources, among the work component, the practice expense component, and the malpractice component, used by physicians in each of such specialties in furnishing physicians’ services. Such percentages shall be based on national data that describe the elements of physician practice costs and revenues, by physician specialty. The Secretary may use extrapolation and other techniques to determine practice costs and revenues for specialties for which adequate data are not available.

“(C) DETERMINATION OF COMPONENT PERCENTAGES.—

“(i) WORK PERCENTAGE.—The work percentage for a service (or class of services) is equal to the sum (for all physician specialties) of—

“(I) the average percentage division for the work component for each physician specialty (determined under subparagraph (B)), multiplied by

“(II) the proportion (determined under subparagraph (A)) of such service (or services) performed by physicians in that specialty.

“(ii) **PRACTICE EXPENSE PERCENTAGE.**—The practice expense percentage for a service (or class of services) is equal to the sum (for all physician specialties) of—

“(I) the average percentage division for the practice expense component for each physician specialty (determined under subparagraph (B)), multiplied by

“(II) by the proportion (determined under subparagraph (A)) of such service (or services) performed by physicians in that specialty.

“(iii) **MALPRACTICE PERCENTAGE.**—The malpractice percentage for a service (or class of services) is equal to the sum (for all physician specialties) of—

“(I) the average percentage division for the malpractice component for each physician specialty (determined under subparagraph (B)), multiplied by

“(II) by the proportion (determined under subparagraph (A)) of such service (or services) performed by physicians in that specialty.

“(D) **PERIODIC RECOMPUTATION.**—The Secretary may, from time to time, provide for the recomputation of work percentages, practice expense percentages, and malpractice percentages determined under this paragraph.

“(3) **ANCILLARY POLICIES.**—The Secretary may establish ancillary policies (with respect to the use of modifiers, local codes, and other matters) as may be necessary to implement this subsection.

“(4) **CODING.**—The Secretary shall establish a uniform procedure coding system for the coding of all physicians’ services. The Secretary shall provide for an appropriate coding structure for visits and consultations. The Secretary may incorporate the use of time in the coding for visits and consultations only for services furnished on or after January 1, 1993. The Secretary, in establishing such coding system, shall consult with the Physician Payment Review Commission and other organizations representing physicians.

“(5) **NO VARIATION FOR SPECIALISTS.**—The Secretary may not vary the conversion factor or the number of relative value units for a physicians’ service based on whether the physician furnishing the service is a specialist or based on the type of specialty of the physician.

“(d) **CONVERSION FACTORS.**—

“(1) **ESTABLISHMENT.**—

“(A) **IN GENERAL.**—The conversion factor for each year shall be the conversion factor established under this subsection for the previous year (or, in the case of 1992, specified in subparagraph (B)) adjusted by the update (established under subparagraph (C)) for the year involved.

“(B) **SPECIAL PROVISION FOR 1992.**—For purposes of subparagraph (A), the conversion factor specified in this sub-

paragraph is a conversion factor (determined by the Secretary) which, if this section were to apply during 1991 using such conversion factor, would result in the same aggregate amount of payments under this part for physicians' services as the estimated aggregate amount of the payments under this part for such services in 1991.

"(C) PUBLICATION.—The Secretary shall cause to have published in the Federal Register, during the last 15 days of October of—

"(i) 1991, the conversion factor (or factors) which will apply to physicians' services for 1992, and the update (or updates) determined under paragraph (3) for 1992; and

"(ii) each succeeding year, the update (or updates) determined under paragraph (3) for the following year.

"(2) RECOMMENDATION OF UPDATE.—

"(A) IN GENERAL.—Not later than April 15 of each year (beginning with 1991), the Secretary shall transmit to the Congress a report that includes a recommendation on the appropriate update (or updates) in the conversion factor (or factors) for all physicians' services in the following year. The Secretary may recommend a uniform update or different updates for different categories or groups of services. In making the recommendation, the Secretary shall consider—

"(i) the percentage change in the medicare economic index (described in the fourth sentence of section 1842(b)(3)) for that year;

"(ii) the percentage by which actual expenditures for all physicians' services (as defined in subsection (f)(5)(A)) under this part for the fiscal year ending in the year preceding the year in which such recommendation is made were greater or less than actual expenditures for all such physicians' services in the fiscal year ending in the second preceding year;

"(iii) the relationship between the percentage determined under clause (ii) for a fiscal year and the performance standard rate of increase (established under subsection (f)(2)) for that fiscal year;

"(iv) changes in volume or intensity of services;

"(v) access to services; and

"(vi) other factors that may contribute to changes in volume or intensity of services or access to services.

For purposes of making the comparison under clause (iii), the Secretary shall adjust the performance standard rate of increase for a fiscal year to reflect changes in the actual proportion of HMO enrollees (as defined in subsection (f)(5)(B)) in that fiscal year compared with such proportion for the previous fiscal year.

"(B) ADDITIONAL CONSIDERATIONS.—In making recommendations under subparagraph (A), the Secretary may also consider—

"(i) unexpected changes by physicians in response to the implementation of fee schedule;

"(ii) unexpected changes in outlay projections;

“(iii) change in the quality or appropriateness of care; and

“(iv) any other relevant factors not measured in the resource-based payment methodology.

“(C) *SPECIAL RULE FOR 1992 UPDATE.*—In considering the update for 1992, the Secretary shall make a separate determination of the percentage and relationship described in clauses (ii) and (iii) of subparagraph (A) with respect to the category of surgical services (as defined by the Secretary pursuant to subsection (j)(1)).

“(D) *EXPLANATION OF UPDATE.*—The Secretary shall include in each report under subparagraph (A)—

“(i) the update recommended for each category of physicians’ services (established by the Secretary under subsection (j)(1)) and for each of the following groups of physicians’ services: nonsurgical services, visits, consultations, and emergency room services;

“(ii) the rationale for the recommended update (or updates) for each category and group of services described in clause (i); and

“(iii) the data and analyses underlying the update (or updates) recommended.

“(E) *COMPUTATION OF BUDGET-NEUTRAL ADJUSTMENT.*—

“(i) *IN GENERAL.*—The Secretary shall include in the report made under subparagraph (A) in a year a statement of the percentage by which (I) the actual expenditures for physicians’ services under this part (during the fiscal year ending in the preceding year, as set forth in most recent annual report made pursuant to section 1841(b)(2)), exceeded, or was less than (II) the expenditures projected for the fiscal year under clause (ii).

“(ii) *PROJECTED EXPENDITURES.*—For purposes of clause (i), the expenditures projected under this clause for a fiscal year is the actual expenditures for physicians’ services made under this part in the second preceding fiscal year—

“(I) increased by the weighted average percentage increase permitted under this part for physicians’ services in the preceding fiscal year;

“(II) adjusted to reflect the percentage change in the average number of individuals enrolled under this part (who are not enrolled with a risk-sharing contract under section 1876) for the preceding fiscal year compared with the second preceding fiscal year;

“(III) adjusted to reflect the average annual percentage growth in the volume and intensity of physicians’ services under this part for the five-fiscal-year period ending with the second preceding fiscal year; and

“(IV) adjusted to reflect the percentage change in expenditures for physicians’ services under this part in the preceding fiscal year (compared with

the second preceding fiscal year) which result from changes in law or regulations.

“(F) COMMISSION REVIEW.—The Physician Payment Review Commission shall review the report submitted under subparagraph (A) in a year and shall submit to the Congress, by not later than May 15 of the year, a report including its recommendations respecting the update (or updates) in the conversion factor (or factors) for the following year.

“(3) UPDATE.—

“(A) BASED ON INDEX.—

“(i) IN GENERAL.—Unless Congress otherwise provides, subject to subparagraph (B), for purposes of this section the update for a year is equal to the Secretary’s estimate of the percentage increase in the appropriate update index (as defined in clause (ii)) for the year.

“(ii) APPROPRIATE UPDATE INDEX DEFINED.—In clause (i), the term ‘appropriate update index’ means—

“(I) for services for which prevailing charges in 1989 were subject to a limit under the fourth sentence of section 1842(b)(3), the medicare economic index (referred to in that sentence), and

“(II) for other services, such index (such as the consumer price index) that was applicable under this part in 1989 to increases in the payment amounts recognized under this part with respect to such services.

“(B) ADJUSTMENT IN UPDATE.—

“(i) IN GENERAL.—The update for a year provided under subparagraph (A) shall, subject to clause (ii), be increased or decreased by the same percentage by which (I) the percentage increase in the actual expenditures for physicians’ services (as defined in section (f)(5)(A)) in the second previous fiscal year over the third previous fiscal year, was less or greater, respectively, than the performance standard rate of increase (established under subsection (f)) for such category of services for the second previous fiscal year.

“(ii) RESTRICTIONS ON ADJUSTMENT.—The adjustment made under clause (i) for a year may not result in a decrease of—

“(I) more than 2 percentage points for the update for 1992 or 1993,

“(II) 2 ½ percentage points for the update for 1994 or 1995, and

“(III) 3 percentage points for the update for any succeeding year.

“(e) GEOGRAPHIC ADJUSTMENT FACTORS.—

“(1) ESTABLISHMENT OF GEOGRAPHIC INDICES.—

“(A) IN GENERAL.—Subject to subparagraph (B), the Secretary shall establish—

“(i) an index which reflects the relative costs of the mix of goods and services comprising practice expenses (other than malpractice expenses) in the different fee

schedule areas compared to the national average of such costs,

“(ii) an index which reflects the relative costs of malpractice expenses in the different fee schedule areas compared to the national average of such costs, and

“(iii) an index which reflects $\frac{1}{4}$ of the difference between the relative value of physicians’ work effort in each of the different fee schedule areas and the national average of such work effort.

“(B) CLASS-SPECIFIC GEOGRAPHIC COST-OF-PRACTICE INDICES.—The Secretary may establish more than one index under subparagraph (A)(i) in the case of classes of physicians’ services, if, because of differences in the mix of goods and services comprising practice expenses for the different classes of services, the application of a single index under such clause to different classes of such services would be substantially inequitable.

“(2) COMPUTATION OF GEOGRAPHIC ADJUSTMENT FACTOR.—For purposes of subsection (b)(1)(C), for all physicians’ services for each fee schedule area the Secretary shall establish a geographic adjustment factor equal to the sum of the geographic cost-of-practice adjustment factor (specified in paragraph (3)), the geographic malpractice adjustment factor (specified in paragraph (4)), and the geographic physician work adjustment factor (specified in paragraph (5)) for the service and the area.

“(3) GEOGRAPHIC COST-OF-PRACTICE ADJUSTMENT FACTOR.—For purposes of paragraph (2), the ‘geographic cost-of-practice adjustment factor’, for a service for a fee schedule area, is the product of—

“(A) the proportion of the total relative value for the service that reflects the relative value units for the practice expense component, and

“(B) the geographic cost-of-practice index value for the area for the service, based on the index established under paragraph (1)(A)(i) or (1)(B) (as the case may be).

“(4) GEOGRAPHIC MALPRACTICE ADJUSTMENT FACTOR.—For purposes of paragraph (2), the ‘geographic malpractice adjustment factor’, for a service for a fee schedule area, is the product of—

“(A) the proportion of the total relative value for the service that reflects the relative value units for the malpractice component, and

“(B) the geographic malpractice index value for the area, based on the index established under paragraph (1)(A)(ii).

“(5) GEOGRAPHIC PHYSICIAN WORK ADJUSTMENT FACTOR.—For purposes of paragraph (2), the ‘geographic physician work adjustment factor’, for a service for a fee schedule area, is the product of—

“(A) the proportion of the total relative value for the service that reflects the relative value units for the work component, and

“(B) the geographic physician work index value for the area, based on the index established under paragraph (1)(A)(iii).

“(f) MEDICARE VOLUME PERFORMANCE STANDARD RATES OF INCREASE.—

“(1) PROCESS FOR ESTABLISHING MEDICARE VOLUME PERFORMANCE STANDARD RATES OF INCREASE.—

“(A) SECRETARY’S RECOMMENDATION.—By not later than April 15 of each year (beginning with 1990), the Secretary shall transmit to the Congress a recommendation on performance standard rates of increase for all physicians’ services and for each category of such services for the fiscal year beginning in such year. In making the recommendation, the Secretary shall confer with organizations representing physicians and shall consider—

- “(i) inflation,
- “(ii) changes in numbers of enrollees (other than HMO enrollees) under this part,
- “(iii) changes in the age composition of enrollees (other than HMO enrollees) under this part,
- “(iv) changes in technology,
- “(v) evidence of inappropriate utilization of services,
- “(vi) evidence of lack of access to necessary physicians’ services, and
- “(vii) such other factors as the Secretary considers appropriate.

“(B) COMMISSION REVIEW.—The Physician Payment Review Commission shall review the recommendation transmitted during a year under subparagraph (A) and shall make its recommendation to Congress, by not later than May 15 of the year, respecting the performance standard rates of increase for the fiscal year beginning in that year.

“(C) PUBLICATION OF PERFORMANCE STANDARD RATES OF INCREASE.—The Secretary shall cause to have published in the Federal Register, in the last 15 days of October of each year (beginning with 1990), the performance standard rates of increase for all physicians’ services and for each category of physicians’ services for the fiscal year beginning in that year. The Secretary shall cause to have published in the Federal Register, by not later than January 1, 1990, the performance standard rate of increase under subparagraph (D) for fiscal year 1990.

“(D) PERFORMANCE STANDARD RATE OF INCREASE FOR FISCAL YEAR 1990.—The performance standard rate of increase for fiscal year 1990 is equal to the sum of—

- “(i) the Secretary’s estimate of the weighted average percentage increase in the reasonable charges for physicians’ services (as defined in subsection (f)(5)(A)) under this part for calendar years included in fiscal year 1990,
- “(ii) the Secretary’s estimate of the percentage increase or decrease in the average number of individuals enrolled under this part (other than HMO enrollees) from fiscal year 1989 to fiscal year 1990,
- “(iii) the Secretary’s estimate of the average annual percentage growth in volume and intensity of physi-

cians' services under this part for the 5-fiscal-year period ending with fiscal year 1989 (based upon information contained in the most recent annual report made pursuant to section 1841(b)(2)) by the Trustees of the calculated by the Trust, and

"(iv) the Secretary's estimate of the percentage increase or decrease in expenditures for physicians' services (as defined in subsection (f)(5)(A)) in fiscal year 1990 (compared with fiscal year 1989) which will result from changes in law or regulations and which is not taken into account in the percentage increase described in clause (i),

reduced by $\frac{1}{2}$ percent.

"(2) SPECIFICATION OF PERFORMANCE STANDARD RATES OF INCREASE FOR SUBSEQUENT FISCAL YEARS.—

"(A) IN GENERAL.—Unless Congress otherwise provides, subject to paragraph (4), each performance standard rates of increase for a fiscal year (beginning with fiscal year 1991) shall be equal to the sum of—

"(i) the Secretary's estimate of the weighted average percentage increase in the fees for physicians' services (as defined in subsection (f)(5)(A)) under this part for calendar years included in the fiscal year involved,

"(ii) the Secretary's estimate of the percentage increase or decrease in the average number of individuals enrolled under this part (other than HMO enrollees) from the previous fiscal year to the fiscal year involved,

"(iii) the Secretary's estimate of the average annual percentage growth in volume and intensity of physicians' services under this part for the 5-fiscal-year period ending with the preceding fiscal year (based upon information contained in the most recent annual report made pursuant to section 1841(b)(2)), and

"(iv) the Secretary's estimate of the percentage increase or decrease in expenditures for physicians' services (as defined in subsection (f)(5)(A)) in the fiscal year (compared with the preceding fiscal year) which will result from changes in law or regulations and which is not taken into account in the percentage increase described in clause (i),

reduced by the performance standard factor (specified in subparagraph (B)). In clause (i), the term 'fees' means, with respect to 1991, reasonable charges and, with respect to any succeeding year, fee schedule amounts.

"(B) PERFORMANCE STANDARD FACTOR.—For purposes of subparagraph (A), the performance standard factor—

"(i) for 1991 is 1 percentage point,

"(ii) for 1992 is $1\frac{1}{2}$ percentage points, and

"(iii) for each succeeding year is 2 percentage points.

"(3) QUARTERLY REPORTING.—The Secretary shall establish procedures for providing, on a quarterly basis to the Physician Payment Review Commission, the Congressional Budget Office, the Congressional Research Service, the Committees on Ways

and Means and Energy and Commerce of the House of Representatives, and the Committee on Finance of the Senate, information on compliance with performance standard rates of increase established under this subsection.

"(4) SEPARATE-GROUP SPECIFIC PERFORMANCE STANDARD RATES OF INCREASE.—

"(A) IMPLEMENTATION OF PLAN.—Subject to paragraph (B), the Secretary shall after completion of the study required under section 6102(e)(3) of the Omnibus Budget Reconciliation Act of 1989, but not before October 1, 1991, implement a plan under which qualified physician groups could elect annually separate performance standard rates of increase other than the performance standard rate of increase established for the year under paragraph (1) for such physicians. The Secretary shall develop criteria to determine which physician groups are eligible to elect to have applied to such groups separate performance standard rates of increase and the methods by which such group-specific performance standard rates of increase would be accomplished. The Secretary shall report to the Congress on the criteria and methods by April 15, 1991. The Physician Payment Review Commission shall review and comment on such recommendations by May 15, 1991. Before implementing group specific performance standard rates of increase, the Secretary shall provide for notice and comment in the Federal Register and consult with organizations representing physicians.

"(B) APPROVAL.—The Secretary may not implement the plan described in subparagraph (A), unless Congress specifically approves the plan.

"(5) DEFINITIONS.—In this subsection:

"(A) SERVICES INCLUDED IN PHYSICIANS' SERVICES.—The term 'physicians' services' includes other items and services (such as clinical diagnostic laboratory tests and radiology services), specified by the Secretary, that are commonly performed or furnished by a physician or in a physician's office, but does not include services furnished to an HMO enrollee under a risk-sharing contract under section 1876.

"(B) HMO ENROLLEE.—The term 'HMO enrollee' means, with respect to a fiscal year, an individual enrolled under this part who is enrolled with an entity under a risk-sharing contract under section 1876 in the fiscal year.

"(g) LIMITATION ON BENEFICIARY LIABILITY.—

"(1) LIMITATION ON ACTUAL CHARGES FOR UNASSIGNED CLAIMS.—If a nonparticipating physician knowingly and willfully bills on a repeated basis for physicians' services (furnished with respect to an individual enrolled under this part on or after January 1, 1991) an actual charge in excess of the limiting charge described in paragraph (2) and for which payment is not made on an assignment-related basis under this part, the Secretary may apply sanctions against such physician in accordance with section 1842(j)(2).

"(2) LIMITING CHARGE DEFINED.—

“(A) FOR 1991.—For physicians’ services of a physician furnished during 1991, the ‘limiting charge’ shall be the same percentage (or, if less, 25 percent) above the recognized payment amount under this part with respect to the physician (as a nonparticipating physician) as the percentage by which—

“(i) the maximum allowable actual charge (as determined under section 1842(j)(1)(C) as of December 31, 1990, or, if less, the maximum actual charge otherwise permitted for the service under this part as of such date) for the service of the physician, exceeds

“(ii) the recognized payment amount for the service of the physician (as a nonparticipating physician) as of such date.

“(B) FOR 1992.—For physicians’ services furnished during 1992, the ‘limiting charge’ shall be the same percentage (or, if less, 20 percent) above the recognized payment amount under this part for nonparticipating physicians as the percentage by which—

“(i) the limiting charge (as determined under subparagraph (A) as of December 31, 1991) for the service, exceeds

“(ii) the recognized payment amount for the service for nonparticipating physicians as of such date.

“(C) AFTER 1992.—For physicians’ services furnished in a year after 1992, the ‘limiting charge’ shall be 115 percent of the recognized payment amount under this part for nonparticipating physicians.

“(D) RECOGNIZED PAYMENT AMOUNT.—In this section, the term ‘recognized payment amount’ means, for services furnished on or after January 1, 1992, the fee schedule amount determined under subsection (a), and, for services furnished during 1991, the applicable percentage (as defined in section 1842(b)(4)(A)(iv)) of the prevailing charge (or fee schedule amount) for nonparticipating physicians for that year.

“(3) LIMITATION ON CHARGES FOR MEDICARE BENEFICIARIES ELIGIBLE FOR MEDICAID BENEFITS.—

“(A) IN GENERAL.—Payment for physicians’ services furnished on or after April 1, 1990, to an individual who is enrolled under this part and eligible for any medical assistance (including as a qualified medicare beneficiary, as defined in section 1905(p)(1)) with respect to such services under a State plan approved under title XIX may only be made on an assignment-related basis.

“(B) PENALTY.—A person may not bill for physicians’ services subject to subparagraph (A) other than on an assignment-related basis. If a person knowingly and willfully bills for physicians’ services in violation of the previous sentence, the Secretary may apply sanctions against the person in accordance with section 1842(j)(2).

“(4) PHYSICIAN SUBMISSION OF CLAIMS.—

“(A) IN GENERAL.—For services furnished on or after September 1, 1990, within 1 year after the date of providing a service for which payment is made under this part on a rea-

sonable charge or fee schedule basis, a physician, supplier, or other person (or an employer or facility in the cases described in section 1842(b)(6)(A))—

“(i) shall complete and submit a claim for such service on a standard claim form specified by the Secretary to the carrier on behalf of a beneficiary, and

“(ii) may not impose any charge relating to completing and submitting such a form.

“(B) **PENALTY.**—(i) With respect to an assigned claim wherever a physician, provider, supplier or other person (or an employer or facility in the cases described in section 1842(b)(6)(A)) fails to submit such a claim as required in subparagraph (A), the Secretary shall reduce by 10 percent the amount that would otherwise be paid for such claim under this part.

“(ii) If a physician, supplier, or other person (or an employer or facility in the cases described in section 1842(b)(6)(A)) fails to submit a claim required to be submitted under subparagraph (A) or imposes a charge in violation of such subparagraph, the Secretary shall apply the sanction with respect to such a violation in the same manner a sanction may be imposed under section 1842(p)(3) for a violation of section 1842(p)(1).

“(5) **ELECTRONIC BILLING, DIRECT DEPOSIT.**—The Secretary shall encourage and develop a system providing for expedited payment for claims submitted electronically. The Secretary shall also encourage and provide incentives allowing for direct deposit as payments for services furnished by participating physicians. The Secretary shall provide physicians with such technical information as necessary to enable such physicians to submit claims electronically. The Secretary shall submit a plan to Congress on this paragraph by May 1, 1990.

“(6) **MONITORING OF CHARGES.**—

“(A) **IN GENERAL.**—The Secretary shall monitor—

“(i) the actual charges of nonparticipating physicians for physicians’ services furnished on or after January 1, 1991, to individuals enrolled under this part, and

“(ii) changes (by specialty, type of service, and geographic area) in (I) the proportion of expenditures for physicians’ services provided under this part by participating physicians, (II) the proportion of expenditures for such services for which payment is made under this part on an assignment-related basis, and (III) the amounts charged above the recognized payment amounts under this part.

“(B) **REPORT.**—The Secretary shall, by not later than April 15 of each year (beginning in 1992), report to the Congress regarding the changes described in subparagraph (A)(ii).

“(C) **PLAN.**—If the Secretary finds that there has been a significant decrease in the proportions described in subclauses (I) and (II) of subparagraph (A)(ii) or an increase in the amounts described in subclause (III) of that subparagraph, the Secretary shall develop a plan to address such a

problem and transmit to Congress recommendations regarding the plan. The Physician Payment Review Commission shall review the Secretary's plan and recommendations and transmit to Congress its comments regarding such plan and recommendations.

"(7) MONITORING OF UTILIZATION AND ACCESS.—

"(A) IN GENERAL.—The Secretary shall monitor—

"(i) changes in the utilization of and access to services furnished under this part within geographic, population, and service related categories,

"(ii) possible sources of inappropriate utilization of services furnished under this part which contribute to the overall level of expenditures under this part, and

"(iii) factors underlying these changes and their interrelationships.

"(B) REPORT.—The Secretary shall by not later than April 15, of each year (beginning with 1991) report to the Congress on the changes described in subparagraph (A)(i) and shall include in the report an examination of the factors (including factors relating to different services and specific categories and groups of services and geographic and demographic variations in utilization) which may contribute to such changes.

"(C) RECOMMENDATIONS.—The Secretary shall include in each annual report under subparagraph (B) recommendations—

"(i) addressing any identified patterns of inappropriate utilization,

"(ii) on utilization review,

"(iii) on physician education or patient education,

"(iv) addressing any problems of beneficiary access to care made evident by the monitoring process, and

"(v) on such other matters as the Secretary deems appropriate.

The Physician Payment Review Commission shall comment on the Secretary's recommendations and in developing its comments, the Commission shall convene and consult a panel of physician experts to evaluate the implications of medical utilization patterns for the quality of and access to patient care.

"(h) SENDING INFORMATION TO PHYSICIANS.—Before the beginning of each year (beginning with 1992), the Secretary shall send to each physician furnishing physicians' services under this part, for services commonly performed by the physician, information on fee schedule amounts that apply for the year in the fee schedule area for participating and non-participating physicians, and the maximum amount that may be charged consistent with subsection (g)(2). Such information shall be transmitted in conjunction with notices to physicians under section 1842(h) (relating to the participating physician program) for a year.

"(i) MISCELLANEOUS PROVISIONS.—

“(1) RESTRICTION ON ADMINISTRATIVE AND JUDICIAL REVIEW.—There shall be no administrative or judicial review under section 1869 or otherwise of—

“(A) the determination of the historical payment basis (as defined in subsection (a)(2)(C)(i)),

“(B) the determination of relative values and relative value units under subsection (c),

“(C) the determination of conversion factors under subsection (d),

“(D) the establishment of geographic adjustment factors under subsection (e), and

“(E) the establishment of the system for the coding of physicians’ services under this section.

“(j) DEFINITIONS.—In this section:

“(1) CATEGORY.—The term ‘category’ means, with respect to physicians’ services, surgical services, and all physicians’ services other than surgical services, and such other category or categories of physicians’ services as the Secretary, from time to time, defines in regulation. The Secretary shall define surgical services and publish such definition in the Federal Register no later than May 1, 1990, after consultation with organizations representing physicians.

“(2) FEE SCHEDULE AREA.—The term ‘fee schedule area’ means a locality used under section 1842(b) for purposes of computing payment amounts for physicians’ services.

“(3) PHYSICIANS’ SERVICES.—The term ‘physicians’ services’ includes items and services described in paragraphs (1), (2)(A), (2)(D), (3), and (4) of section 1861(s) (other than clinical diagnostic laboratory tests and such other items and services as the Secretary may specify).

“(4) PRACTICE EXPENSES.—The term ‘practice expenses’ includes all expenses for furnishing physicians’ services, excluding malpractice expenses, physician compensation, and other physician fringe benefits.”

(c) REQUIREMENTS FOR CARRIERS TO PROFILE PHYSICIANS.—Section 1842(b)(3) of such Act (42 U.S.C. 1395u(b)(3)) is amended—

(1) by striking “and” at the end of subparagraph (J),

(2) by inserting “and” at the end of subparagraph (K), and

(3) by inserting after subparagraph (K) the following new subparagraph:

“(L) will monitor and profile physicians’ billing patterns within each area or locality and provide comparative data to physicians whose utilization patterns vary significantly from other physicians in the same payment area or locality;”

(d) RURAL AND INNER-CITY ACCESS ADJUSTMENTS.—

(1) ADJUSTMENTS.—Section 1833(m) of such Act (42 U.S.C. 1395l(m)) is amended—

(A) by striking “class 1 or class 2”, and

(B) by striking “5 percent” and inserting “10 percent”

(2) EFFECTIVE DATE.—The amendments made by paragraph

(1) shall apply to services furnished on or after January 1, 1991.

(e) STUDIES.—

(1) **GAO STUDY OF ALTERNATIVE PAYMENT METHODOLOGY FOR MALPRACTICE COMPONENT.**—The Comptroller General shall provide for—

(A) a study of alternative ways of paying, under section 1848 of the Social Security Act, for the malpractice component for physicians' services, in a manner that would assure, to the extent practicable, payment for medicare's share of malpractice insurance premiums, and

(B) a study to examine alternative resolution procedures for malpractice claims respecting professional services furnished under the medicare program.

The examination under subparagraph (B) shall include review of the feasibility of establishing procedures that involve no-fault payment or that involve mandatory arbitration. By not later than April 1, 1991, the Comptroller General shall submit a report to Congress on the results of the studies.

(2) **STUDY OF PAYMENTS TO RISK-CONTRACTING PLANS.**—The Secretary of Health and Human Services (in this subsection referred to as the "Secretary") shall conduct a study of how payments under section 1848 of the Social Security Act may affect payments to eligible organizations with risk-sharing contracts under section 1876 of such Act. By not later than April 1, 1990, the Secretary shall submit a report to Congress on such study and shall include in the report such recommendations for such changes in the methodology for payment under such risk-sharing contracts as the Secretary deems appropriate.

(3) **STUDY OF VOLUME PERFORMANCE STANDARD RATES OF INCREASE BY GEOGRAPHY, SPECIALTY, AND TYPE OF SERVICE.**—The Secretary shall conduct a study of the feasibility of establishing, under section 1848(f) of the Social Security Act, separate performance standard rates of increase for services furnished by or within each of the following (including combinations of the following):

(A) Geographic area (such as a region, State, or other area).

(B) Specialty or group of specialties of physicians.

(C) Type of services (such as primary care, services of hospital-based physicians, and other inpatient services).

Such study shall also include the scope of services included within, or excluded from, the rate of increase in expenditure system. By not later than July 1, 1990, the Secretary shall submit a report to Congress on such study and shall include in the report such recommendations respecting the feasibility of establishing separate target rates of increase in expenditures as it deems appropriate.

(4) **HHS VISIT CODE MODIFICATION STUDY.**—The Secretary shall conduct a study of the desirability of including time as a factor in establishing visit codes. By not later than July 1, 1991, the Secretary shall consult with the Physician Payment Review Commission, and submit a report to Congress on such study and shall include in the report recommendations respecting the desirability of modifying the number of visit codes, whether greater coding uniformity would result from including time in visit codes when compared with clarifying the clinical descriptions

of existing codes, and the ability to audit physician time accurately.

(5) *COMMISSION STUDY OF PAYMENT FOR PRACTICE EXPENSES.*—The Physician Payment Review Commission shall conduct a study of—

(A) the extent to which practice costs and malpractice costs vary by geographic locality (including region, State, Metropolitan Statistical Areas, or other areas and by specialty),

(B) the extent to which available geographic practice-cost indices accurately reflect practice costs and malpractice costs in rural areas,

(C) which geographic units would be most appropriate to use in measuring and adjusting practice costs and malpractice costs,

(D) appropriate methods for allocating malpractice expenses to particular procedures which could be incorporated into the determination of relative values for particular procedures using a consensus panel and other appropriate methodologies,

(E) the effect of alternative methods of allocating malpractice expenses on Medicare expenditures by specialty, type of service, and by geographic area, and

(F) the special circumstances of rural independent laboratories in determining the geographic cost-of-practice index.

By not later than July 1, 1991, the Commission shall submit a report to the Committees on Ways and Means and Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate on the study and shall include in the report such recommendations as it deems appropriate.

(6) *COMMISSION STUDY OF GEOGRAPHIC PAYMENT AREAS.*—The Physician Payment Review Commission shall conduct a study of the feasibility and desirability of using Metropolitan Statistical Areas or other payment areas for purposes of payment for physicians' services under part B of title XVIII of the Social Security Act. By not later than July 1, 1991, the Commission shall submit a report to Congress on such study and shall include in the report recommendations on the desirability of retaining current carrier-wide localities, changing to a system of statewide localities, or adopting Metropolitan Statistical Areas or other payment areas for purposes of payment under such part B.

(7) *COMMISSION STUDY OF PAYMENT FOR NON-PHYSICIAN PROVIDERS OF MEDICARE SERVICES.*—The Physician Payment Review Commission shall conduct a study of the implications of a resource-based fee schedule for physicians' services for non-physician practitioners, such as physician assistants, clinical psychologists, nurse midwives, and other health practitioners whose services can be billed under the medicare program on a fee-for-service basis. The study shall address (A) what the proper level of payment should be for these practitioners, (B) whether or not adjustments to their payments should be subject to the medicare volume performance standard process, and (C) what update to use for services outside the medicare volume performance standard rates of increase. The Commission shall

submit a report to Congress on such study by not later than July 1, 1991.

(8) **COMMISSION STUDY OF PHYSICIAN FEES UNDER MEDICAID.**—The Physician Payment Review Commission shall conduct a study on physician fees under State medicaid programs established under title XIX of the Social Security Act. The Commission shall specifically examine in such study the adequacy of physician reimbursement under such programs, physician participation in such programs, and access to care by medicaid beneficiaries. By no later than July 1, 1991, the Commission shall submit a report to Congress on such study and shall include such recommendations as the Commission deems appropriate.

(9) **GAO STUDY ON PHYSICIAN ANTI-TRUST ISSUES.**—The Comptroller General shall conduct a study of the effect of anti-trust laws on the ability of physicians to act in groups to educate and discipline peers of such physicians in order to reduce and eliminate ineffective practice patterns and inappropriate utilization. The study shall further address anti-trust issues as they relate to the adoption of practice guidelines by third-party payers and the role that practice guidelines might play as a defense in malpractice cases. By no later than July 1, 1991, the Comptroller General shall submit a report to Congress on such study and shall make such recommendations as the Comptroller General deems appropriate.

(f) **MISCELLANEOUS CONFORMING AMENDMENTS.**—

(1) **REFERENCE TO NEW PAYMENT RULES.**—Section 1833(a)(1) of the Social Security Act (42 U.S.C. 13951(a)(1)) is amended by—

(A) striking “and” before clause (M), and

(B) by inserting before the period the following new clause: “and (N) with respect to expenses incurred for physicians’ services (as defined in section 1848(j)(3)), the amounts paid shall be 80 percent of the payment basis determined under section 1848(a)(1)”.

(2) **CHANGING REFERENCES TO MAXIMUM ALLOWABLE ACTUAL CHARGES.**—Section 1842(b)(3)(G) of such Act (42 U.S.C. 1395u(b)(3)(G)) is amended by striking “maximum allowable actual charges (established under subsection (j)(1)(C))” and inserting “limiting charges established under subsection (j)(1)(C)”.

(3) **DIFFERENTIAL FOR PARTICIPATING PHYSICIANS.**—Effective for physicians’ services furnished on or after January 1, 1992, the first sentence of section 1842(b)(4)(A)(iv) of such Act (42 U.S.C. 1395u(b)(4)(A)(iv)) is amended by inserting “and before January 1, 1992,” after “January 1, 1987,”.

(4) **PAYMENT FOR PHYSICIAN ASSISTANTS.**—Section 1842(b)(12)(A)(ii)(II) of such Act (42 U.S.C. 1395u(b)(12)(A)(ii)(II)) is amended by inserting “(or, for services furnished on or after January 1, 1992, the fee schedule amount specified in section 1848, as the case may be)” after “prevailing charge rate for such services”.

(5) **PAYMENT FOR CERTIFIED REGISTERED NURSE ANESTHETISTS.**—Section 1833(a)(1)(H) of such Act (42 U.S.C. 1395l(a)(1)(H)) is amended by inserting “(or, for services furnished on or after January 1, 1992, the fee schedule amount

provided under section 1848, as the case may be)" after "prevailing charge that would be recognized".

(6) **PAYMENT FOR RADIOLOGIST SERVICES.**—(A) Section 1833(a)(1)(J) of such Act (42 U.S.C. 1395l(a)(1)(J)) is amended by inserting "subject to section 1848," before "the amounts".

(B) Section 4049(b)(2) of the Omnibus Budget Reconciliation Act of 1987 is amended by striking ", and until" and all that follows through "Social Security Act".

(7) **PAYMENT FOR NURSE MIDWIVES.**—Section 1833(a)(1)(K) of the Social Security Act (42 U.S.C. 1395l(a)(1)(K)) is amended by inserting ", or, for services furnished on or after January 1, 1992, 65 percent of the fee schedule amount provided under section 1848 for the same service performed by a physician" after "for the same service performed by a physician".

(8) **PHYSICIANS' SERVICES FOR INDIVIDUALS WITH END STAGE RENAL DISEASE.**—Section 1881(b)(3)(A) of such Act (42 U.S.C. 1395rr(b)(3)(A)) is amended by inserting "or, for services furnished on or after January 1, 1992, on the basis described in section 1848" after "comparable services".

(9) **EXTENSION OF MAXIMUM ALLOWABLE ACTUAL CHARGE LIMITS.**—Subparagraphs (B)(ii) and (D)(v) of section 1842(j)(1) of such Act (42 U.S.C. 1395u(j)(1)) are each amended by striking all that follows "after" and inserting "December 31, 1990."

(10) **TREATMENT OF CERTAIN EYE EXAMINATION VISITS AS PRIMARY CARE SERVICES.**—In applying section 1842(i)(4) of the Social Security Act for services furnished on or after January 1, 1990, intermediate and comprehensive office visits for eye examinations and treatments (codes 92002 and 92004) shall be considered to be primary care services.

(11) **DISTRIBUTION OF MODEL FEE SCHEDULE.**—By September 1, 1990, the Secretary shall develop a Model Fee Schedule, using the methodology set forth in section 1848 of the Social Security Act. The Model Fee Schedule shall include as many services as the Secretary concludes can be assigned valid relative values. The Secretary shall submit the Model Fee Schedule to the appropriate committees of Congress and make it generally available to the public.

(g) **PAYMENT FOR PATHOLOGY SERVICES.**—

(1) **FEE SCHEDULE.**—Section 1834 of the Social Security Act (42 U.S.C. 1395m) is amended by adding at the end the following new subsection:

"(f) **FEE SCHEDULE FOR PHYSICIAN PATHOLOGY SERVICES.**—

"(1) **APPLICATION.**—Subject to section 1848, the Secretary shall provide for application of a fee schedule with respect to physician pathology services. Subject to paragraph (2), such fee schedule shall be based on relative values developed by the Secretary, in consultation with organizations representing physicians performing such services. Such fee schedule shall be designed so as to result in expenditures under this part for services covered under the schedule in an amount that would not exceed the amount of such expenditures which would otherwise occur. In developing such fee schedule the Secretary shall take into account the special circumstances of rural independent laboratories.

“(2) GEOGRAPHIC AREA ADJUSTMENT.—The Secretary shall provide for a geographic area adjustment of the conversion factors in a manner comparable to the geographic area adjustment applied to physicians’ services under section 1848 during the year in which the services are furnished.”

(2) PAYMENT ON BASIS OF FEE SCHEDULE.—Section 1833(a)(1)(J) of such Act (42 U.S.C. 1395l(a)(1)(J)) is amended—

(A) by inserting “or physician pathology services” after “1834(b)(6))”, and

(B) by inserting “or section 1834(f), respectively” after “1834(b)”.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to services furnished on or after January 1, 1991.

(h) EFFECTIVE DATE.—Except as otherwise provided in this section, this section, and the amendments made by this section, shall take effect on the date of the enactment of this Act.

SEC. 6103. ESTABLISHMENT OF AGENCY FOR HEALTH CARE POLICY AND RESEARCH.

(a) IN GENERAL.—The Public Health Service Act (42 U.S.C. 201 et seq.) is amended by inserting after title VIII the following new title:

“TITLE IX—AGENCY FOR HEALTH CARE POLICY AND RESEARCH

“PART A—ESTABLISHMENT AND GENERAL DUTIES

“SEC. 901. ESTABLISHMENT.

“(a) IN GENERAL.—There is established within the Service an agency to be known as the Agency for Health Care Policy and Research.

“(b) PURPOSE.—The purpose of the Agency is to enhance the quality, appropriateness, and effectiveness of health care services, and access to such services, through the establishment of a broad base of scientific research and through the promotion of improvements in clinical practice and in the organization, financing, and delivery of health care services.

“(c) APPOINTMENT OF ADMINISTRATOR.—There shall be at the head of the Agency an official to be known as the Administrator for Health Care Policy and Research. The Administrator shall be appointed by the Secretary. The Secretary, acting through the Administrator, shall carry out the authorities and duties established in this title.

“SEC. 902. GENERAL AUTHORITIES AND DUTIES.

“(a) IN GENERAL.—In carrying out section 901(b), the Administrator shall conduct and support research, demonstration projects, evaluations, training, guideline development, and the dissemination of information, on health care services and on systems for the delivery of such services, including activities with respect to—

“(1) the effectiveness, efficiency, and quality of health care services;

“(2) subject to subsection (d), the outcomes of health care services and procedures;

“(3) clinical practice, including primary care and practice-oriented research;

“(4) health care technologies, facilities, and equipment;

“(5) health care costs, productivity, and market forces;

“(6) health promotion and disease prevention;

“(7) health statistics and epidemiology; and

“(8) medical liability.

“(b) **REQUIREMENTS WITH RESPECT TO RURAL AREAS AND UNDERSERVED POPULATIONS.**—In carrying out subsection (a), the Administrator shall undertake and support research, demonstration projects, and evaluations with respect to—

“(1) the delivery of health care services in rural areas (including frontier areas); and

“(2) the health of low-income groups, minority groups, and the elderly.

“(c) **MULTIDISCIPLINARY CENTERS.**—The Administrator may provide financial assistance to public or nonprofit private entities for meeting the costs of planning and establishing new centers, and operating existing and new centers, for multidisciplinary health services research, demonstration projects, evaluations, training, policy analysis, and demonstrations respecting the matters referred to in subsection (b).

“(d) **RELATION TO CERTAIN AUTHORITIES REGARDING SOCIAL SECURITY.**—Activities authorized in this section may include, and shall be appropriately coordinated with, experiments, demonstration projects, and other related activities authorized by the Social Security Act and the Social Security Amendments of 1967. Activities under subsection (a)(2) of this section that affect the programs under titles XVIII and XIX of the Social Security Act shall be carried out consistent with section 1142 of such Act.

“SEC. 903. DISSEMINATION.

“(a) **IN GENERAL.**—The Administrator shall—

“(1) promptly publish, make available, and otherwise disseminate, in a form understandable and on as broad a basis as practicable so as to maximize its use, the results of research, demonstration projects, and evaluations conducted or supported under this title and the guidelines, standards, and review criteria developed under this title;

“(2) promptly make available to the public data developed in such research, demonstration projects, and evaluations;

“(3) provide indexing, abstracting, translating, publishing, and other services leading to a more effective and timely dissemination of information on research, demonstration projects, and evaluations with respect to health care to public and private entities and individuals engaged in the improvement of health care delivery and the general public, and undertake programs to develop new or improved methods for making such information available; and

“(4) as appropriate, provide technical assistance to State and local government and health agencies and conduct liaison activities to such agencies to foster dissemination.

“(b) **PROHIBITION AGAINST RESTRICTIONS.**—Except as provided in subsection (c), the Administrator may not restrict the publication or

dissemination of data from, or the results of, projects conducted or supported under this title.

“(c) *LIMITATION ON USE OF CERTAIN INFORMATION.*—No information, if an establishment or person supplying the information or described in it is identifiable, obtained in the course of activities undertaken or supported under this title may be used for any purpose other than the purpose for which it was supplied unless such establishment or person has consented (as determined under regulations of the Secretary) to its use for such other purpose. Such information may not be published or released in other form if the person who supplied the information or who is described in it is identifiable unless such person has consented (as determined under regulations of the Secretary) to its publication or release in other form.

“(d) *CERTAIN INTERAGENCY AGREEMENT.*—The Administrator and the Director of the National Library of Medicine shall enter into an agreement providing for the implementation of subsection (a)(3).

“*SEC. 904. HEALTH CARE TECHNOLOGY AND TECHNOLOGY ASSESSMENT.*

“(a) *IN GENERAL.*—In carrying out section 901(b), the Administrator shall promote the development and application of appropriate health care technology assessments—

“(1) by identifying needs in, and establishing priorities for, the assessment of specific health care technologies;

“(2) by developing and evaluating criteria and methodologies for health care technology assessment;

“(3) by conducting and supporting research on the development and diffusion of health care technology;

“(4) by conducting and supporting research on assessment methodologies; and

“(5) by promoting education, training, and technical assistance in the use of health care technology assessment methodologies and results.

“(b) *SPECIFIC ASSESSMENTS.*—

“(1) *IN GENERAL.*—In carrying out section 901(b), the Administrator shall conduct and support specific assessments of health care technologies.

“(2) *CONSIDERATION OF CERTAIN FACTORS.*—In carrying out paragraph (1), the Administrator shall consider the safety, efficacy, and effectiveness, and, as appropriate, the cost-effectiveness, legal, social, and ethical implications, and appropriate uses of such technologies, including consideration of geographic factors.

“(c) *INFORMATION CENTER.*—

“(1) *IN GENERAL.*—There shall be established at the National Library of Medicine an information center on health care technologies and health care technology assessment.

“(2) *INTERAGENCY AGREEMENT.*—The Administrator and the Director of the National Library of Medicine shall enter into an agreement providing for the implementation of paragraph (1).

“(d) *RECOMMENDATIONS WITH RESPECT TO HEALTH CARE TECHNOLOGY.*—

“(1) *IN GENERAL.*—The Administrator shall make recommendations to the Secretary with respect to whether specific health care technologies should be reimbursable under federally fi-

nanced health programs, including recommendations with respect to any conditions and requirements under which any such reimbursements should be made.

“(2) *CONSIDERATION OF CERTAIN FACTORS.*—In making recommendations respecting health care technologies, the Administrator shall consider the safety, efficacy, and effectiveness, and, as appropriate, the cost-effectiveness and appropriate uses of such technologies.

“(3) *CONSULTATIONS.*—In carrying out this subsection, the Administrator shall cooperate and consult with the Director of the National Institutes of Health, the Commissioner of Food and Drugs, and the heads of any other interested Federal department or agency.

“PART B—FORUM FOR QUALITY AND EFFECTIVENESS IN HEALTH CARE

“SEC. 911. ESTABLISHMENT OF OFFICE.

“There is established within the Agency an office to be known as the Office of the Forum for Quality and Effectiveness in Health Care. The office shall be headed by a director, who shall be appointed by the Administrator.

“SEC. 912. DUTIES.

“(a) *ESTABLISHMENT OF FORUM PROGRAM.*—The Administrator, acting through the Director, shall establish a program to be known as the Forum for Quality and Effectiveness in Health Care. For the purpose of promoting the quality, appropriateness, and effectiveness of health care, the Director, using the process set forth in section 913, shall arrange for the development and periodic review and updating of—

“(1) clinically relevant guidelines that may be used by physicians, educators, and health care practitioners to assist in determining how diseases, disorders, and other health conditions can most effectively and appropriately be prevented, diagnosed, treated, and managed clinically; and

“(2) standards of quality, performance measures, and medical review criteria through which health care providers and other appropriate entities may assess or review the provision of health care and assure the quality of such care.

“(b) *CERTAIN REQUIREMENTS.*—Guidelines, standards, performance measures, and review criteria under subsection (a) shall—

“(1) be based on the best available research and professional judgment regarding the effectiveness and appropriateness of health care services and procedures;

“(2) be presented in formats appropriate for use by physicians, health care practitioners, providers, medical educators, and medical review organizations and in formats appropriate for use by consumers of health care; and

“(3) include treatment-specific or condition-specific practice guidelines for clinical treatments and conditions in forms appropriate for use in clinical practice, for use in educational programs, and for use in reviewing quality and appropriateness of medical care.

“(c) AUTHORITY FOR CONTRACTS.—In carrying out this part, the Director may enter into contracts with public or nonprofit private entities.

“(d) DATE CERTAIN FOR INITIAL GUIDELINES AND STANDARDS.—The Administrator, by not later than January 1, 1991, shall assure the development of an initial set of guidelines, standards, performance measures, and review criteria under subsection (a) that includes not less than 3 clinical treatments or conditions described in section 1142(a)(3) of the Social Security Act.

“(e) RELATIONSHIP WITH MEDICARE PROGRAM.—To assure an appropriate reflection of the needs and priorities of the program under title XVIII of the Social Security Act, activities under this part that affect such program shall be conducted consistent with section 1142 of such Act.

“SEC. 913. PROCESS FOR DEVELOPMENT OF GUIDELINES AND STANDARDS.

“(a) DEVELOPMENT THROUGH CONTRACTS AND PANELS.—The Director shall—

“(1) enter into contracts with public and nonprofit private entities for the purpose of developing and periodically reviewing and updating the guidelines, standards, performance measures, and review criteria described in section 912(a); and

“(2) convene panels of appropriately qualified experts (including practicing physicians with appropriate expertise) and health care consumers for the purpose of—

“(A) developing and periodically reviewing and updating the guidelines, standards, performance measures, and review criteria described in section 912(a); and

“(B) reviewing the guidelines, standards, performance measures, and review criteria developed under contracts under paragraph (1).

“(b) AUTHORITY FOR ADDITIONAL PANELS.—The Director may convene panels of appropriately qualified experts (including practicing physicians with appropriate expertise) and health care consumers for the purpose of—

“(1) developing the standards and criteria described in section 914(b); and

“(2) providing advice to the Administrator and the Director with respect to any other activities carried out under this part or under section 902(a)(2).

“(c) SELECTION OF PANEL MEMBERS.—In selecting individuals to serve on panels convened under this section, the Director shall consult with a broad range of interested individuals and organizations, including organizations representing physicians in the general practice of medicine and organizations representing physicians in specialties and subspecialties pertinent to the purposes of the panel involved. The Director shall seek to appoint physicians reflecting a variety of practice settings.

“SEC. 914. ADDITIONAL REQUIREMENTS.

“(a) PROGRAM AGENDA.—

“(1) IN GENERAL.—The Administrator shall provide for an agenda for the development of the guidelines, standards, performance measures, and review criteria described in section 912(a), including—

“(A) with respect to the guidelines, identifying specific diseases, disorders, and other health conditions for which the guidelines are to be developed and those that are to be given priority in the development of the guidelines; and

“(B) with respect to the standards, performance measures, and review criteria, identifying specific aspects of health care for which the standards, performance measures, and review criteria are to be developed and those that are to be given priority in the development of the standards, performance measures, and review criteria.

“(2) CONSIDERATION OF CERTAIN FACTORS IN ESTABLISHING PRIORITIES.—

“(A) Factors considered by the Administrator in establishing priorities for purposes of paragraph (1) shall include consideration of the extent to which the guidelines, standards, performance measures, and review criteria involved can be expected—

“(i) to improve methods of prevention, diagnosis, treatment, and clinical management for the benefit of a significant number of individuals;

“(ii) to reduce clinically significant variations among physicians in the particular services and procedures utilized in making diagnoses and providing treatments; and

“(iii) to reduce clinically significant variations in the outcomes of health care services and procedures.

“(B) In providing for the agenda required in paragraph (1), including the priorities, the Administrator shall consult with the Administrator of the Health Care Financing Administration and otherwise act consistent with section 1142(b)(3) of the Social Security Act.

“(b) STANDARDS AND CRITERIA.—

“(1) PROCESS FOR DEVELOPMENT, REVIEW, AND UPDATING.—
The Director shall establish standards and criteria to be utilized by the recipients of contracts under section 913, and by the expert panels convened under such section, with respect to the development and periodic review and updating of the guidelines, standards, performance measures, and review criteria described in section 912(a).

“(2) AWARD OF CONTRACTS.—*The Director shall establish standards and criteria to be utilized for the purpose of ensuring that contracts entered into for the development or periodic review or updating of the guidelines, standards, performance measures, and review criteria described in section 912(a) will be entered into only with appropriately qualified entities.*

“(3) CERTAIN REQUIREMENTS FOR STANDARDS AND CRITERIA.—
The Director shall ensure that the standards and criteria established under paragraphs (1) and (2) specify that—

“(A) appropriate consultations with interested individuals and organizations are to be conducted in the development of the guidelines, standards, performance measures, and review criteria described in section 912(a); and

“(B) such development may be accomplished through the adoption, with or without modification, of guidelines,

standards, performance measures, and review criteria that—

“(i) meet the requirements of this part; and

“(ii) are developed by entities independently of the program established in this part.

“(4) **IMPROVEMENTS OF STANDARDS AND CRITERIA.**—The Director shall conduct and support research with respect to improving the standards and criteria developed under this subsection.

“(c) **DISSEMINATION.**—The Director shall promote and support the dissemination of the guidelines, standards, performance measures, and review criteria described in section 912(a). Such dissemination shall be carried out through organizations representing health care providers, organizations representing health care consumers, peer review organizations, accrediting bodies, and other appropriate entities.

“(d) **PILOT TESTING.**—The Director may conduct or support pilot testing of the guidelines, standards, performance measures, and review criteria developed under section 912(a). Any such pilot testing may be conducted prior to, or concurrently with, their dissemination under subsection (c).

“(e) **EVALUATIONS.**—The Director shall conduct and support evaluations of the extent to which the guidelines, standards, performance standards, and review criteria developed under section 912 have had an effect on the clinical practice of medicine.

“(f) **RECOMMENDATIONS TO ADMINISTRATOR.**—The Director shall make recommendations to the Administrator on activities that should be carried out under section 902(a)(2) and under section 1142 of the Social Security Act, including recommendations of particular research projects that should be carried out with respect to—

“(1) evaluating the outcomes of health care services and procedures;

“(2) developing the standards and criteria required in subsection (b); and

“(3) promoting the utilization of the guidelines, standards, performance standards, and review criteria developed under section 912(a).”

(b) **OUTCOMES OF HEALTH CARE SERVICES AND PROCEDURES.**—

(1) **ESTABLISHMENT OF PROGRAM OF RESEARCH.**—Part A of title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by adding at the end the following new section:

“RESEARCH ON OUTCOMES OF HEALTH CARE SERVICES AND PROCEDURES

“SEC. 1142. (a) **ESTABLISHMENT OF PROGRAM.**—

“(1) **IN GENERAL.**—The Secretary, acting through the Administrator for Health Care Policy and Research, shall—

“(A) conduct and support research with respect to the outcomes, effectiveness, and appropriateness of health care services and procedures in order to identify the manner in which diseases, disorders, and other health conditions can most effectively and appropriately be prevented, diagnosed, treated, and managed clinically; and

“(B) assure that the needs and priorities of the program under title XVIII are appropriately reflected in the development and periodic review and updating (through the process set forth in section 913 of the Public Health Service Act) of treatment-specific or condition-specific practice guidelines for clinical treatments and conditions in forms appropriate for use in clinical practice, for use in educational programs, and for use in reviewing quality and appropriateness of medical care.

“(2) **EVALUATIONS OF ALTERNATIVE SERVICES AND PROCEDURES.**—In carrying out paragraph (1), the Secretary shall conduct or support evaluations of the comparative effects, on health and functional capacity, of alternative services and procedures utilized in preventing, diagnosing, treating, and clinically managing diseases, disorders, and other health conditions.

“(3) **INITIAL GUIDELINES.**—

“(A) In carrying out paragraph (1)(B) of this subsection, and section 912(d) of the Public Health Service Act, the Secretary shall, by not later than January 1, 1991, assure the development of an initial set of the guidelines specified in paragraph (1)(B) that shall include not less than 3 clinical treatments or conditions that—

“(i)(I) account for a significant portion of expenditures under title XVIII; and

“(II) have a significant variation in the frequency or the type of treatment provided; or

“(ii) otherwise meet the needs and priorities of the program under title XVIII, as set forth under paragraph (b)(3).

“(B)(i) The Secretary shall provide for the use of guidelines developed under subparagraph (A) to improve the quality, effectiveness, and appropriateness of care provided under title XVIII. The Secretary shall determine the impact of such use on the quality, appropriateness, effectiveness, and cost of medical care provided under such title and shall report to the Congress on such determination by not later than January 1, 1993.

“(ii) For the purpose of carrying out clause (i), the Secretary shall expend, from the amounts specified in clause (iii), \$1,000,000 for fiscal year 1990 and \$1,500,000 for each of the fiscal years 1991 and 1992.

“(iii) For each fiscal year, for purposes of expenditures required in clause (ii)—

“(I) 60 percent of an amount equal to the expenditure involved is appropriated from the Federal Hospital Insurance Trust Fund (established under section 1817); and

“(II) 40 percent of an amount equal to the expenditure involved is appropriated from the Federal Supplementary Medical Insurance Trust Fund (established under section 1841).

“(b) **PRIORITIES.**—

“(1) **IN GENERAL.**—The Secretary shall establish priorities with respect to the diseases, disorders, and other health condi-

tions for which research and evaluations are to be conducted or supported under subsection (a). In establishing such priorities, the Secretary shall, with respect to a disease, disorder, or other health condition, consider the extent to which—

“(A) improved methods of prevention, diagnosis, treatment, and clinical management can benefit a significant number of individuals;

“(B) there is significant variation among physicians in the particular services and procedures utilized in making diagnoses and providing treatments or there is significant variation in the outcomes of health care services or procedures due to different patterns of diagnosis or treatment;

“(C) the services and procedures utilized for diagnosis and treatment result in relatively substantial expenditures; and

“(D) the data necessary for such evaluations are readily available or can readily be developed.

“(2) *PRELIMINARY ASSESSMENTS.*—For the purpose of establishing priorities under paragraph (1), the Secretary may, with respect to services and procedures utilized in preventing, diagnosing, treating, and clinically managing diseases, disorders, and other health conditions, conduct or support assessments of the extent to which—

“(A) rates of utilization vary among similar populations for particular diseases, disorders, and other health conditions;

“(B) uncertainties exist on the effect of utilizing a particular service or procedure; or

“(C) inappropriate services and procedures are provided.

“(3) *RELATIONSHIP WITH MEDICARE PROGRAM.*—In establishing priorities under paragraph (1) for research and evaluation, and under section 914(a) of the Public Health Service Act for the agenda under such section, the Secretary shall assure that such priorities appropriately reflect the needs and priorities of the program under title XVIII, as set forth by the Administrator of the Health Care Financing Administration.

“(c) *METHODOLOGIES AND CRITERIA FOR EVALUATIONS.*—For the purpose of facilitating research under subsection (a), the Secretary shall—

“(1) conduct and support research with respect to the improvement of methodologies and criteria utilized in conducting research with respect to outcomes of health care services and procedures;

“(2) conduct and support reviews and evaluations of existing research findings with respect to such treatment or conditions;

“(3) conduct and support reviews and evaluations of the existing methodologies that use large data bases in conducting such research and shall develop new research methodologies, including data-based methods of advancing knowledge and methodologies that measure clinical and functional status of patients, with respect to such research;

“(4) provide grants and contracts to research centers, and contracts to other entities, to conduct such research on such treat-

ment or conditions, including research on the appropriate use of prescription drugs;

"(5) conduct and support research and demonstrations on the use of claims data and data on clinical and functional status of patients in determining the outcomes, effectiveness, and appropriateness of such treatment; and

"(6) conduct and support supplementation of existing data bases, including the collection of new information, to enhance data bases for research purposes, and the design and development of new data bases that would be used in outcomes and effectiveness research.

"(d) **STANDARDS FOR DATA BASES.**—In carrying out this section, the Secretary shall develop—

"(1) uniform definitions of data to be collected and used in describing a patient's clinical and functional status;

"(2) common reporting formats and linkages for such data; and

"(3) standards to assure the security, confidentiality, accuracy, and appropriate maintenance of such data.

"(e) **DISSEMINATION OF RESEARCH FINDINGS AND GUIDELINES.**—

"(1) **IN GENERAL.**—The Secretary shall provide for the dissemination of the findings of research and the guidelines described in subsection (a), and for the education of providers and others in the application of such research findings and guidelines.

"(2) **COOPERATIVE EDUCATIONAL ACTIVITIES.**—In disseminating findings and guidelines under paragraph (1), and in providing for education under such paragraph, the Secretary shall work with professional associations, medical specialty and subspecialty organizations, and other relevant groups to identify and implement effective means to educate physicians, other providers, consumers, and others in using such findings and guidelines, including training for physician managers within provider organizations.

"(f) **EVALUATIONS.**—The Secretary shall conduct and support evaluations of the activities carried out under this section to determine the extent to which such activities have had an effect on the practices of physicians in providing medical treatment, the delivery of health care, and the outcomes of health care services and procedures.

"(g) **RESEARCH WITH RESPECT TO DISSEMINATION.**—The Secretary may conduct or support research with respect to improving methods of disseminating information on the effectiveness and appropriateness of health care services and procedures.

"(h) **REPORT TO CONGRESS.**—Not later than February 1 of each of the years 1991 and 1992, and of each second year thereafter, the Secretary shall report to the Congress on the progress of the activities under this section during the preceding fiscal year (or preceding 2 fiscal years, as appropriate), including the impact of such activities on medical care (particularly medical care for individuals receiving benefits under title XVIII).

"(i) **AUTHORIZATION OF APPROPRIATIONS.**—

"(1) **IN GENERAL.**—There are authorized to be appropriated to carry out this section—

- “(A) \$50,000,000 for fiscal year 1990;
- “(B) \$75,000,000 for fiscal year 1991;
- “(C) \$110,000,000 for fiscal year 1992;
- “(D) \$148,000,000 for fiscal year 1993; and
- “(E) \$185,000,000 for fiscal year 1994.

“(2) *SPECIFICATIONS.*—For the purpose of carrying out this section, for each of the fiscal years 1990 through 1992 an amount equal to two-thirds of the amounts authorized to be appropriated under paragraph (1), and for each of the fiscal years 1993 and 1994 an amount equal to 70 percent of such amounts, are to be appropriated in the following proportions from the following trust funds:

“(A) 60 percent from the Federal Hospital Insurance Trust Fund (established under section 1817).

“(B) 40 percent from the Federal Supplementary Medical Insurance Trust Fund (established under section 1841).

“(3) *ALLOCATIONS.*—

“(A) For each fiscal year, of the amounts transferred or otherwise appropriated to carry out this section, the Secretary shall reserve appropriate amounts for each of the purposes specified in clauses (i) through (iv) of subparagraph (B).

“(B) The purposes referred to in subparagraph (A) are—

“(i) the development of guidelines, standards, performance measures, and review criteria;

“(ii) research and evaluation;

“(iii) data-base standards and development; and

“(iv) education and information dissemination.”

(2) *REPORT ON LINKAGE OF PUBLIC AND PRIVATE RESEARCH-RELATED DATA.*—Not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services shall report to the Congress on the feasibility of linking research-related data described in section 1142(d) of the Social Security Act (as added by subsection (a) of this section) with similar data collected or maintained by non-Federal entities and by Federal agencies other than the Department of Health and Human Services (including the Departments of Defense and Veterans Affairs and the Office of Personnel Management).

(3) *TECHNICAL AND CONFORMING PROVISIONS.*—

(A) Effective for fiscal years beginning after fiscal year 1990, subsection (c) of section 1875 of the Social Security Act (42 U.S.C. 1395ll) is repealed.

(B) Section 1862(a)(1)(E) of the Social Security Act (42 U.S.C. 1395y(a)(1)(E)) is amended by striking “section 1875(c)” and inserting “section 1142”.

(c) *ADDITIONAL AUTHORITIES AND DUTIES WITH RESPECT TO AGENCY FOR HEALTH CARE POLICY AND RESEARCH.*—

(1) *ADVISORY COUNCIL, PEER REVIEW, ADMINISTRATIVE AUTHORITIES, AND OTHER GENERAL PROVISIONS.*—Title IX of the Public Health Service Act, as added by subsection (a) of this section, is amended by adding at the end the following new part:

"PART C—GENERAL PROVISIONS

"SEC. 921. ADVISORY COUNCIL FOR HEALTH CARE POLICY, RESEARCH, AND EVALUATION.

"(a) ESTABLISHMENT.—*There is established an advisory council to be known as the National Advisory Council for Health Care Policy, Research, and Evaluation.*

"(b) DUTIES.—

"(1) IN GENERAL.—*The Council shall advise the Secretary and the Administrator with respect to activities to carry out the purpose of the Agency under section 901(b).*

"(2) CERTAIN RECOMMENDATIONS.—*Activities of the Council under paragraph (1) shall include making recommendations to the Administrator regarding priorities for a national agenda and strategy for—*

"(A) the conduct of research, demonstration projects, and evaluations with respect to health care, including clinical practice and primary care;

"(B) the development and application of appropriate health care technology assessments;

"(C) the development and periodic review and updating of guidelines for clinical practice, standards of quality, performance measures, and medical review criteria with respect to health care;

"(D) the conduct of research on outcomes of health care services and procedures.

"(c) MEMBERSHIP.—

"(1) IN GENERAL.—*The Council shall, in accordance with this subsection, be composed of appointed members and ex officio members. All members of the Council shall be voting members, other than officials designated under paragraph (3)(B) as ex officio members of the Council.*

"(2) APPOINTED MEMBERS.—*The Secretary shall appoint to the Council 17 appropriately qualified representatives of the public who are not officers or employees of the United States. The Secretary shall ensure that the appointed members of the Council, as a group, are representative of professions and entities concerned with, or affected by, activities under this title and under section 1142 of the Social Security Act. Of such members—*

"(A) 8 shall be individuals distinguished in the conduct of research, demonstration projects, and evaluations with respect to health care;

"(B) 3 shall be individuals distinguished in the practice of medicine;

"(C) 2 shall be individuals distinguished in the health professions;

"(D) 2 shall be individuals distinguished in the fields of business, law, ethics, economics, and public policy; and

"(E) 2 shall be individuals representing the interests of consumers of health care.

"(3) EX OFFICIO MEMBERS.—*The Secretary shall designate as ex officio members of the Council—*

“(A) the Director of the National Institutes of Health, the Director of the Centers for Disease Control, the Administrator of the Health Care Financing Administration, the Assistant Secretary of Defense (Health Affairs), the Chief Medical Officer of the Department of Veterans Affairs; and

“(B) such other Federal officials as the Secretary may consider appropriate.

“(d) SUBCOUNCIL ON OUTCOMES AND GUIDELINES.—

“(1) ESTABLISHMENT.—For the purpose of carrying out the duties specified in subparagraphs (C) and (D) of subsection (b)(2), the Secretary shall establish a subcouncil of the Council and shall designate the membership of the subcouncil in accordance with paragraph (2).

“(2) MEMBERSHIP.—The subcouncil established pursuant to paragraph (1) shall consist of—

“(A) 6 individuals from among the individuals appointed to the Council under subparagraphs (A) through (C) of subsection (c)(2);

“(B) 2 individuals from among the individuals appointed to the Council under subparagraphs (D) and (E) of such subsection; and

“(C) each of the officials designated as ex officio members of the Council under subsection (c)(3)(A).

“(e) TERMS.—

“(1) IN GENERAL.—Except as provided in paragraph (2), members of the Council appointed under subsection (c)(2) shall serve for a term of 3 years.

“(2) STAGGERED ROTATION.—Of the members first appointed to the Council under subsection (c)(2), the Secretary shall appoint 5 members to serve for a term of 3 years, 5 members to serve for a term of 2 years, and 5 members to serve for a term of 1 year.

“(3) SERVICE BEYOND TERM.—A member of the Council appointed under subsection (c)(2) may continue to serve after the expiration of the term of the member until a successor is appointed.

“(f) VACANCIES.—If a member of the Council appointed under subsection (c)(2) does not serve the full term applicable under subsection (e), the individual appointed to fill the resulting vacancy shall be appointed for the remainder of the term of the predecessor of the individual.

“(g) CHAIR.—The Administrator shall, from among the members of the Council appointed under subsection (c)(2), designate an individual to serve as the chair of the Council.

“(h) MEETINGS.—The Council shall meet not less than once during each discrete 4-month period and shall otherwise meet at the call of the Administrator or the chair.

“(i) COMPENSATION AND REIMBURSEMENT OF EXPENSES.—

“(1) APPOINTED MEMBERS.—Members of the Council appointed under subsection (c)(2) shall receive compensation for each day (including traveltime) engaged in carrying out the duties of the Council. Such compensation may not be in an amount in excess of the maximum rate of basic pay payable for GS-18 of the General Schedule.

“(2) EX OFFICIO MEMBERS.—Officials designated under subsection (c)(3) as ex officio members of the Council may not receive compensation for service on the Council in addition to the compensation otherwise received for duties carried out as officers of the United States.

“(j) STAFF.—The Administrator shall provide to the Council such staff, information, and other assistance as may be necessary to carry out the duties of the Council.

“(k) DURATION.—Notwithstanding section 14(a) of the Federal Advisory Committee Act, the Council shall continue in existence until otherwise provided by law.

“SEC. 922. PEER REVIEW WITH RESPECT TO GRANTS AND CONTRACTS.

“(a) REQUIREMENT OF REVIEW.—

“(1) IN GENERAL.—Appropriate technical and scientific peer review shall be conducted with respect to each application for a grant, cooperative agreement, or contract under this title.

“(2) REPORTS TO ADMINISTRATOR.—Each peer review group to which an application is submitted pursuant to paragraph (1) shall report its finding and recommendations respecting the application to the Administrator in such form and in such manner as the Administrator shall require.

“(b) APPROVAL AS PRECONDITION OF AWARDS.—The Administrator may not approve an application described in subsection (a)(1) unless the application is recommended for approval by a peer review group established under subsection (c).

“(c) ESTABLISHMENT OF PEER REVIEW GROUPS.—

“(1) IN GENERAL.—The Administrator shall establish such technical and scientific peer review groups as may be necessary to carry out this section. Such groups shall be established without regard to the provisions of title 5, United States Code, that govern appointments in the competitive service, and without regard to the provisions of chapter 51, and subchapter III of chapter 53, of such title that relate to classification and pay rates under the General Schedule.

“(2) MEMBERSHIP.—The members of any peer review group established under this section shall be appointed from among individuals who are not officers or employees of the United States and who by virtue of their training or experience are eminently qualified to carry out the duties of such peer review group.

“(3) DURATION.—Notwithstanding section 14(a) of the Federal Advisory Committee Act, peer review groups established under this section shall continue in existence until otherwise provided by law.

“(d) CATEGORIES OF REVIEW.—

“(1) IN GENERAL.—With respect to technical and scientific peer review under this section, such review of applications with respect to research, demonstration projects, or evaluations shall be conducted by different peer review groups than the peer review groups that conduct such review of applications with respect to dissemination activities or the development of research agendas (including conferences, workshops, and meetings).

“(2) AUTHORITY FOR PROCEDURAL ADJUSTMENTS IN CERTAIN CASES.—In the case of applications described in subsection (a)(1)

for financial assistance whose direct costs will not exceed \$50,000, the Administrator may make appropriate adjustments in the procedures otherwise established by the Administrator for the conduct of peer review under this section. Such adjustments may be made for the purpose of encouraging the entry of individuals into the field of research, for the purpose of encouraging clinical practice-oriented research, and for such other purposes as the Administrator may determine to be appropriate.

“(e) *REGULATIONS.*—The Secretary shall issue regulations for the conduct of peer review under this section.

“SEC. 923. CERTAIN PROVISIONS WITH RESPECT TO DEVELOPMENT, COLLECTION, AND DISSEMINATION OF DATA.

“(a) *STANDARDS WITH RESPECT TO UTILITY OF DATA.*—

“(1) *IN GENERAL.*—With respect to data developed or collected by any entity for the purpose described in section 901(b), the Administrator shall, in order to assure the utility, accuracy, and sufficiency of such data for all interested entities, establish guidelines for uniform methods of developing and collecting such data. Such guidelines shall include specifications for the development and collection of data on the outcomes of health care services and procedures.

“(2) *RELATIONSHIP WITH MEDICARE PROGRAM.*—In any case where guidelines under paragraph (1) may affect the administration of the program under title XVIII of the Social Security Act, the guidelines shall be in the form of recommendations to the Secretary for such program.

“(b) *STATISTICS.*—The Administrator shall—

“(1) take such action as may be necessary to assure that statistics developed under this title are of high quality, timely, and comprehensive, as well as specific, standardized, and adequately analyzed and indexed; and

“(2) publish, make available, and disseminate such statistics on as wide a basis as is practicable.

“SEC. 924. ADDITIONAL PROVISIONS WITH RESPECT TO GRANTS AND CONTRACTS.

“(a) *REQUIREMENT OF APPLICATION.*—The Administrator may not, with respect to any program under this title authorizing the provision of grants, cooperative agreements, or contracts, provide any such financial assistance unless an application for the assistance is submitted to the Secretary and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Administrator determines to be necessary to carry out the program involved.

“(b) *PROVISION OF SUPPLIES AND SERVICES IN LIEU OF FUNDS.*—

“(1) *IN GENERAL.*—Upon the request of an entity receiving a grant, cooperative agreement, or contract under this title, the Secretary may, subject to paragraph (2), provide supplies, equipment, and services for the purpose of aiding the entity in carrying out the project involved and, for such purpose, may detail to the entity any officer or employee of the Department of Health and Human Services.

“(2) *CORRESPONDING REDUCTION IN FUNDS.*—With respect to a request described in paragraph (1), the Secretary shall reduce

the amount of the financial assistance involved by an amount equal to the costs of detailing personnel and the fair market value of any supplies, equipment, or services provided by the Administrator. The Secretary shall, for the payment of expenses incurred in complying with such request, expend the amounts withheld.

“(c) APPLICABILITY OF CERTAIN PROVISIONS WITH RESPECT TO CONTRACTS.—Contracts may be entered into under this part without regard to sections 3648 and 3709 of the Revised Statutes (31 U.S.C. 529; 41 U.S.C. 5).

“SEC. 925. CERTAIN ADMINISTRATIVE AUTHORITIES.

“(a) DEPUTY ADMINISTRATOR AND OTHER OFFICERS AND EMPLOYEES.—

“(1) DEPUTY ADMINISTRATOR.—The Administrator may appoint a deputy administrator for the Agency.

“(2) OTHER OFFICERS AND EMPLOYEES.—The Administrator may appoint and fix the compensation of such officers and employees as may be necessary to carry out this title. Except as otherwise provided by law, such officers and employees shall be appointed in accordance with the civil service laws and their compensation fixed in accordance with title 5, United States Code.

“(b) FACILITIES.—The Secretary, in carrying out this title—

“(1) may acquire, without regard to the Act of March 3, 1877 (40 U.S.C. 34), by lease or otherwise through the Administrator of General Services, buildings or portions of buildings in the District of Columbia or communities located adjacent to the District of Columbia for use for a period not to exceed 10 years; and

“(2) may acquire, construct, improve, repair, operate, and maintain laboratory, research, and other necessary facilities and equipment, and such other real or personal property (including patents) as the Secretary deems necessary.

“(c) PROVISION OF FINANCIAL ASSISTANCE.—The Administrator, in carrying out this title, may make grants to, and enter into cooperative agreements with, public and nonprofit private entities and individuals, and when appropriate, may enter into contracts with public and private entities and individuals.

“(d) UTILIZATION OF CERTAIN PERSONNEL AND RESOURCES.—

“(1) DEPARTMENT OF HEALTH AND HUMAN SERVICES.—The Administrator, in carrying out this title, may utilize personnel and equipment, facilities, and other physical resources of the Department of Health and Human Services, permit appropriate (as determined by the Secretary) entities and individuals to utilize the physical resources of such Department, and provide technical assistance and advice.

“(2) OTHER AGENCIES.—The Administrator, in carrying out this title, may use, with their consent, the services, equipment, personnel, information, and facilities of other Federal, State, or local public agencies, or of any foreign government, with or without reimbursement of such agencies.

“(e) CONSULTANTS.—The Secretary, in carrying out this title, may secure, from time to time and for such periods as the Administrator deems advisable but in accordance with section 3109 of title 5,

United States Code, the assistance and advice of consultants from the United States or abroad.

"(f) EXPERTS.—

"(1) IN GENERAL.—The Secretary may, in carrying out this title, obtain the services of not more than 50 experts or consultants who have appropriate scientific or professional qualifications. Such experts or consultants shall be obtained in accordance with section 3109 of title 5, United States Code, except that the limitation in such section on the duration of service shall not apply.

"(2) TRAVEL EXPENSES.—

"(A) Experts and consultants whose services are obtained under paragraph (1) shall be paid or reimbursed for their expenses associated with traveling to and from their assignment location in accordance with sections 5724, 5724a(a)(1), 5724a(a)(3), and 5726(c) of title 5, United States Code.

"(B) Expenses specified in subparagraph (A) may not be allowed in connection with the assignment of an expert or consultant whose services are obtained under paragraph (1) unless and until the expert agrees in writing to complete the entire period of assignment, or one year, whichever is shorter, unless separated or reassigned for reasons that are beyond the control of the expert or consultant and that are acceptable to the Secretary. If the expert or consultant violates the agreement, the money spent by the United States for the expenses specified in subparagraph (A) is recoverable from the expert or consultant as a debt of the United States. The Secretary may waive in whole or in part a right of recovery under this subparagraph.

"(g) VOLUNTARY AND UNCOMPENSATED SERVICES.—The Administrator, in carrying out this title, may accept voluntary and uncompensated services.

"SEC. 926. FUNDING.

"(a) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this title, there are authorized to be appropriated \$35,000,000 for fiscal year 1990, \$50,000,000 for fiscal year 1991, and \$70,000,000 for fiscal year 1992.

"(b) EVALUATIONS.—In addition to amounts available pursuant to subsection (a) for carrying out this title, there shall be made available for such purpose, from the amounts made available pursuant to section 2611 of this Act (relating to evaluations), an amount equal to 40 percent of the maximum amount authorized in such section 2611 to be made available.

"SEC. 927. DEFINITIONS.

"For purposes of this title:

"(1) The term 'Administrator' means the Administrator for Health Care Policy and Research.

"(2) The term 'Agency' means the Agency for Health Care Policy and Research.

"(3) The term 'Council' means the National Advisory Council on Health Care Policy, Research, and Evaluation.

"(4) The term 'Director' means the Director of the Office of the Forum for Quality and Effectiveness in Health Care."

(d) *GENERAL PROVISIONS.—*(1) *TERMINATIONS.—*

(A) *The National Center for Health Services Research and Health Care Technology Assessment is terminated, and part A of title III of the Public Health Service Act (42 U.S.C. 241 et seq.) is amended by striking section 305.*

(B) *The council on health care technology established under section 309 of the Public Health Service Act is terminated, and part A of title III of such Act is amended by striking such section 309.*

(2) *CONTRACT FOR TEMPORARY ASSISTANCE TO SECRETARY WITH RESPECT TO HEALTH CARE TECHNOLOGY ASSESSMENT.—*

(A) *The Secretary of Health and Human Services shall request the Institute of Medicine of the National Academy of Sciences to enter into a contract—*

(i) to develop and recommend to the Secretary priorities for the assessment of specific health care technologies under section 904 of the Public Health Service Act (as added by subsection (a) of this section); and

(ii) to assist the Administrator for Health Care Policy and Research, and the Director of the National Library of Medicine, in establishing the information center required under subsection (c)(1) of such section 904.

(B) *In carrying out section 904(c)(1) of the Public Health Service Act (as added by subsection (a) of this section), the Secretary of Health and Human Services shall, as appropriate, provide for the transfer to the Secretary of any information and materials developed by the council on health care technology under section 309(c)(1)(A) of the Public Health Service Act (as such section was in effect on the day before the effective date of this section).*

(C) *The Secretary of Health and Human Services shall ensure that the contract under subparagraph (A) specifies that the activities described in clauses (i) and (ii) of such subparagraph shall be completed not later than 1 year after the date on which the Secretary enters into the contract.*

(D) *For the purpose of carrying out the contract under subparagraph (A), there is authorized to be appropriated \$300,000 for fiscal year 1990.*

(e) *TECHNICAL AND CONFORMING AMENDMENTS.—*

(1) *SECTION 304.—Section 304 of the Public Health Service Act (42 U.S.C. 242b) is amended—*

(A) in subsection (a)—

(i) by striking paragraphs (1) and (2); and

(ii) by striking the paragraph designation in paragraph (3);

(B) in subsection (a) (as amended by subparagraph (A) of this paragraph—

(i) by striking “the National Center for Health Services Research and Health Care Technology Assessment” and inserting “the Agency for Health Care Policy and Research”; and

(ii) by striking “in sections 305, 306, and 309” and inserting “in section 306 and in title IX”;

(C) in subsection (b), in the matter preceding paragraph (1), by striking “subsection (a),” and inserting “subsection (a) and section 306,”; and

(D) in subsection (c)—

(i) in paragraph (1), in the second sentence, by striking “the National Center for Health Services Research and Health Care Technology Assessment” and inserting “the Agency for Health Care Policy and Research”; and

(ii) in paragraph (2), by striking “the National Center for Health Services Research and Health Care Technology Assessment” and inserting “the Agency for Health Care Policy and Research”.

(2) SECTION 306.—Section 306 of the Public Health Service Act (42 U.S.C. 242k) is amended—

(A) in subsection (a), by adding at the end the following new sentence: “The Secretary, acting through the Center, shall conduct and support statistical and epidemiological activities for the purpose of improving the effectiveness, efficiency, and quality of health services in the United States.”;

(B) in subsection (b), in the matter preceding paragraph (1), by striking “section 304(a),” and inserting “subsection (a),”; and

(C) by adding at the end the following new subsection:

“(m) For health statistical and epidemiological activities undertaken or supported under this section, there are authorized to be appropriated \$55,000,000 for fiscal year 1988 and such sums as may be necessary for each of the fiscal years 1989 and 1990.”.

(3) SECTION 307.—Section 307(a) of the Public Health Service Act (42 U.S.C. 242l(a)) is amended by striking “sections 304, 305, 306, and 309” and inserting “section 306 and by title IX”.

(4) SECTION 308.—Section 308 of the Public Health Service Act (42 U.S.C. 242m) is amended—

(A) in the section heading, by striking “SECTIONS” and all that follows and inserting the following: “EFFECTIVENESS, EFFICIENCY, AND QUALITY OF HEALTH SERVICES”;

(B) in subsection (a)—

(i) in paragraph (1)(A)(i), by striking “sections 304 through 307 and section 309” and inserting “sections 304, 306, and 307 and title IX”; and

(ii) in paragraph (2), by striking “the National Center for Health Services Research and Health Care Technology Assessment” and inserting “the Agency for Health Care Policy and Research”;

(C) in subsection (b)—

(i) in paragraph (1), by striking “sections 304, 305, 306, 307, and 309” and inserting “section 304, 306, or 307”;

(ii) in subparagraph (A) of paragraph (2)—

(I) in the first sentence, by striking "under section 304 or 305," and inserting "under section 306";

(II) by striking the second sentence; and

(III) by amending the last sentence to read as follows: "The Director of the National Center for Health Statistics shall establish such peer review groups as may be necessary to provide for such an evaluation of each such application.";

(iii) in subparagraph (B) of paragraph (2), by striking "the Director involved," and inserting "the Director of the National Center for Health Statistics,";

(iv) in subparagraph (C) of paragraph (2), by striking "the Directors," and inserting "the Director of the National Center for Health Statistics,"; and

(v) in paragraph (3), in the first sentence—

(I) by striking "section 304, 305, or 306" the first place such term appears and inserting "section 306"; and

(II) by striking "section 304, 305, or 306" the second place such term appears and inserting "any of such sections";

(D) in subsection (d)—

(i) in the matter preceding paragraph (1), by striking "section 304, 305, 306, 307, or 309" and inserting "section 304, 306, or 307";

(ii) in paragraph (1), by striking "in other form, and" and inserting "in other form." and by striking the paragraph designation; and

(ii) by striking paragraph (2);

(E) in subsection (e)—

(i) in paragraph (1), by striking "section 304, 305, 306, 307, or 309" and inserting "section 304, 306, or 307"; and

(ii) in paragraph (2), in the matter preceding subparagraph (A), by striking "section 304, 305, 306, 307, or 309" and inserting "section 304, 306, or 307";

(F) in subsection (f), by striking "section 304, 305, 306, or 309" and inserting "section 304 or 306";

(G) in subsection (g)—

(i) in paragraph (1), by striking the matter after and below subparagraph (C); and

(ii) in paragraph (2), by striking "sections 304, 305, 306, and 309" and inserting "sections 304 and 306";

(H) in subsection (h)(1)—

(i) by striking "section 304, 305, 306, or 309" the first place such term appears and inserting "section 306"; and

(ii) by striking "section 304, 305, 306, or 309" the second place such term appears and inserting "any of such sections"; and

(I) by striking subsection (i).

(5) SECTION 330.—Section 330(e)(3)(G)(i) of the Public Health Service Act (42 U.S.C. 254c(e)(3)(G)(i)) is amended by inserting

after “(i)” the following: “except in the case of an entity operated by an Indian tribe or tribal or Indian organization under the Indian Self-Determination Act,”.

(6) **SECTION 402.—SECTION 402 OF THE PUBLIC HEALTH SERVICE AMENDMENTS OF 1987 IS AMENDED—**

(A) by redesignating subsection (c) as subsection (d) and by inserting after subsection (b) the following new subsection:

“(c) Such Act is amended in section 411(c)(2) by striking subparagraph (B), by striking ‘subparagraphs (A) and (B)’ in subparagraph (C), and by redesignating subparagraph (C) as subparagraph (B). Such Act is amended in section 415(a) by inserting before the period at the end the following: ‘or as preempting or overriding any State law which provides incentives, immunities, or protection for those engaged in a professional review action that is in addition to or greater than that provided by this part’”; and

(B) in subsection (d)(1) (as so redesignated), by striking “subsection (a)” and inserting “subsections (a) and (c)”.

(7) **SECTION 487.—Section 487(d)(3)(B) of the Public Health Service Act (42 U.S.C. 288(d)(3)(B)) is amended by striking “National Center” and all that follows through “Assessment” and inserting “Agency for Health Care Policy and Research”.**

(f) **TRANSITIONAL AND SAVINGS PROVISIONS.—**

(1) **TRANSFER OF PERSONNEL, ASSETS, AND LIABILITIES.—**Personnel of the Department of Health and Human Services employed on the date of the enactment of this Act in connection with the functions vested in the Administrator for Health Care Policy and Research pursuant to the amendments made by this section, and assets, property, contracts, liabilities, records, unexpended balances of appropriations, authorizations, allocations, and other funds, of such Department arising from or employed, held, used, or available on such date, or to be made available after such date, in connection with such functions shall be transferred to the Administrator for appropriate allocation. Unexpended funds transferred under this subsection shall be used only for the purposes for which the funds were originally authorized and appropriated.

(2) **SAVINGS PROVISIONS.—**With respect to functions vested in the Administrator for Health Care Policy and Research pursuant to the amendments made by this section, all orders, rules, regulations, grants, contracts, certificates, licenses, privileges, and other determinations, actions, or official documents, of the Department of Health and Human Services that have been issued, made, granted, or allowed to become effective in the performance of such functions, and that are effective on the date of the enactment of this Act, shall continue in effect according to their terms unless changed pursuant to law.

SEC. 6104. REDUCTION IN PAYMENTS FOR CERTAIN PROCEDURES.

(a) **IN GENERAL.—**Section 1842(b) of the Social Security Act (42 U.S.C. 1395u(b)) is amended by adding at the end the following new paragraph:

“(14)(A) In determining the reasonable charge for a physicians’ service specified in subparagraph (C)(i) and furnished during the 9-

month period beginning on April 1, 1990, the prevailing charge for such service shall be the prevailing charge otherwise recognized for such service for 1989 reduced by 15 percent or, if less, $\frac{1}{3}$ of the percent (if any) by which the prevailing charge otherwise applied in the locality in 1989 exceeds the locally-adjusted reduced prevailing amount (as determined under subparagraph (B)(i)) for the service.

“(B) For purposes of this paragraph:

“(i) The ‘locally-adjusted reduced prevailing amount’ for a locality for a physicians’ service is equal to the product of—

“(I) the reduced national weighted average prevailing charge for the service (specified under clause (ii)), and

“(II) the adjustment factor (specified under clause (iii)) for the locality.

“(ii) The ‘reduced national weighted average prevailing charge’ for a physicians’ service is equal to the national weighted average prevailing charge for the service (specified in subparagraph (C)(ii)) reduced by the percentage change (specified in subparagraph (C)(iii)) for the service.

“(iii) The ‘adjustment factor’, for a physicians’ service for a locality, is the sum of—

“(I) the practice expense ratio for the service (specified in Table #1 in the Joint Explanatory Statement referred to in subparagraph (C)(i)), multiplied by the geographic practice cost index value (specified in subparagraph (C)(iv)) for the locality, and

“(II) 1 minus the practice expense ratio.

“(C) For purposes of this paragraph:

“(i) The physicians’ services specified in this clause are the physicians’ services specified in Table #2 in the Joint Explanatory Statement of the Committee of Conference submitted with the Conference Report to accompany H.R. 3299 (the ‘Omnibus Budget Reconciliation Act of 1989’), 101st Congress, which specification is of physicians’ services that have been identified as overvalued by at least 10 percent based on a comparison of payments for such services under a resource-based relative value scale and of the national average prevailing charges under this part.

“(ii) The ‘national weighted average prevailing charge’ specified in this clause, for a physicians’ service specified in clause (i), is the national weighted average prevailing charge for the service in 1989 as determined by the Secretary using the best data available.

“(iii) The ‘percent change’ specified in this clause, for a physicians’ service specified in clause (i), is the percent change specified for the service in Table #2 in the Joint Explanatory Statement referred in clause (i).

“(iv) The geographic practice cost index value specified in this clause for a locality is such value specified for the locality in Table #3 in the Joint Explanatory Statement referred to in clause (i).

“(D) In the case of a reduction in the prevailing charge for a physicians’ service under subparagraph (A), if a nonparticipating physician furnishes the service to an individual entitled to benefits under

this part, after the effective date of such reduction, the physician's actual charge is subject to a limit under subsection (j)(1)(D).”

(b) **SPECIAL LIMITS ON ACTUAL CHARGES.**—Section 1842(j)(1)(D) of such Act is amended—

(1) in clause (ii)(II), by inserting “or (b)(14)(A)” after “(b)(10)(A)”, and

(2) in clause (iii)(II), by striking “or (b)(11)(C)(i)” and inserting “(b)(11)(C)(i), or (b)(14)(A)”.

SEC. 6105. REDUCTION IN PAYMENTS FOR RADIOLOGY SERVICES.

(a) **FEE SCHEDULES FOR RADIOLOGIST SERVICES REDUCED.**—Section 1834(b)(4) of the Social Security Act (42 U.S.C. 1395m(b)(4)) is amended—

(1) by redesignating subparagraphs (C) and (D) as subparagraphs (D) and (E), and

(2) by inserting after subparagraph (B) the following new subparagraph:

“(C) 1990 FEE SCHEDULES.—For radiologist services (other than portable X-ray services) furnished under this part during 1990, after March 31 of such year, the conversion factors used under this subsection shall be 96 percent of the conversion factors that applied under this subsection as of December 31, 1989.”

(b) **SPECIAL RULE FOR NUCLEAR MEDICINE PHYSICIANS.**—In applying section 1834(b) of the Social Security Act with respect to nuclear medicine services furnished by a physician for whom nuclear medicine services account for at least 80 percent of the total amount of charges made under part B of title XVIII of the Social Security Act—

(1) during 1990, after April 1, 1990, there shall be substituted for the fee schedule otherwise applicable a fee schedule based $\frac{1}{3}$ on the fee schedule computed under such section (without regard to this subsection) and $\frac{2}{3}$ on 101 percent of the 1988 prevailing charge for such services; and

(2) during 1991, there shall be substituted for the fee schedule otherwise applicable a fee schedule based $\frac{2}{3}$ on the fee schedule computed under such section (without regard to this subsection) and $\frac{1}{3}$ on 101 percent of the 1988 prevailing charge for such services.

(c) **INTERVENTIONAL RADIOLOGISTS.**—In applying section 1834(b) of the Social Security Act to radiologist services furnished in 1990, the exception for “split billing” set forth at section 5262J of the Medicare Carriers Manual shall apply to services furnished in 1990 in the same manner and to the same extent as the exception applied to services furnished in 1989.

SEC. 6106. ANESTHESIA SERVICES.

(a) **COUNTING ACTUAL TIME UNITS FOR ANESTHESIA SERVICES AND CODIFICATION OF PREVIOUS AUTHORITY.**—Section 1842 of the Social Security Act (42 U.S.C. 1395u) is amended by adding at the end the following new subsection:

“(q)(1) The Secretary, in consultation with groups representing physicians who furnish anesthesia services, shall establish by regulation a relative value guide for use in all carrier localities in making payment for physician anesthesia services furnished under

this part. Such guide shall be designed so as to result in expenditures under this title for such services in an amount that would not exceed the amount of such expenditures which would otherwise occur.

“(2) For purposes of payment for anesthesia services (whether furnished by physicians or by certified registered nurse anesthetists) under this part, the time units shall be counted based on actual time rather than rounded to full time units.”

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall apply to services furnished on or after April 1, 1990.

SEC. 6107. DELAY IN UPDATE AND REDUCTION IN PERCENTAGE INCREASE IN THE MEDICARE ECONOMIC INDEX.

(a) **DELAYING UPDATES UNTIL APRIL 1.**—

(1) **IN GENERAL.**—Subject to the amendments made by this section, any increase or adjustment in customary, prevailing, or reasonable charges, fee schedule amounts, maximum allowable actual charges, and other limits on actual charges with respect to physicians' services and other items and services described in paragraph (2) under part B of title XVIII of the Social Security Act which would otherwise occur as of January 1, 1990, shall be delayed so as to occur as of April 1, 1990, and, notwithstanding any other provision of law, the amount of payment under such part for such items and services which are furnished during the period beginning on January 1, 1990, and ending on March 31, 1990, shall be determined on the same basis as the amount of payment for such services furnished on December 31, 1989.

(2) **ITEMS AND SERVICES COVERED.**—The items and services described in this paragraph are items and services (other than ambulance services and clinical diagnostic laboratory services) for which payment is made under part B of title XVIII of the Social Security Act on the basis of a reasonable charge or a fee schedule.

(3) **EXTENSION OF PARTICIPATION AGREEMENTS AND RELATED PROVISIONS.**—Notwithstanding any other provision of law—

(A) subject to the last sentence of this paragraph, each participation agreement in effect on December 31, 1989, under section 1842(h)(1) of the Social Security Act shall remain in effect for the 3-month period beginning on January 1, 1990;

(B) the effective period for such agreements under such section entered into for 1990 shall be the 9-month period beginning on April 1, 1990, and the Secretary of Health and Human Services shall provide an opportunity for physicians and suppliers to enroll as participating physicians and suppliers before April 1, 1990;

(C) instead of publishing, under section 1842(h)(4) of the Social Security Act, at the beginning of 1990, directories of participating physicians and suppliers for 1990, the Secretary shall provide for such publication, at the beginning of the 9-month period beginning on April 1, 1990, of such directories of participating physicians and suppliers for such period; and

(D) instead of providing to nonparticipating physicians under section 1842(b)(3)(G) of the Social Security Act at the beginning of 1990, a list of maximum allowable actual charges for 1990, the Secretary shall provide, at the beginning of the 9-month period beginning on April 1, 1990, such physicians such a list for such 9-month period.

An agreement with a participating physician or supplier described in subparagraph (A) in effect on December 31, 1989, under section 1842(h)(1) of the Social Security Act shall not remain in effect for the period described in subparagraph (A) if the participating physician or supplier requests on or before December 31, 1989, that the agreement be terminated.

(b) **PERCENTAGE INCREASE IN MEI FOR 1990.**—Section 1842(b)(4)(E) of the Social Security Act (42 U.S.C. 1395u(b)(4)(E)) is amended by adding at the end the following new clause:

“(iv) For purposes of this part for items and services furnished in 1990, after March 31, 1990, the percentage increase in the MEI is—

“(I) 0 percent for radiology services, for anesthesia services, and for other services specified in Table #2 in the Joint Explanatory Statement of the Committee of Conference submitted with the Conference Report to accompany H.R. 3299 (the ‘Omnibus Budget Reconciliation Act of 1989’), 101st Congress,

“(II) 2 percent for other services (other than primary care services), and

“(III) such percentage increase in the MEI (as defined in subsection (i)(3)) as would be otherwise determined for primary care services (as defined in subsection (i)(4)).”

SEC. 6108. MISCELLANEOUS PROVISIONS RELATING TO PAYMENT FOR PHYSICIANS’ SERVICES.

(a) **CUSTOMARY CHARGE FOR NEW PHYSICIANS.**—

(1) **PHASE-IN TO PREVAILING CHARGE LEVEL.**—Section 1842(b)(4)(F) of the Social Security Act (42 U.S.C. 1395u(b)(4)(F)) is amended—

(A) by inserting “furnished during a calendar year” after “physicians’ services”, and

(B) by adding at the end the following: “For the first calendar year during which the preceding sentence no longer applies, the Secretary shall set the customary charge at a level no higher than 85 percent of the prevailing charge for the service.”

(2) **EFFECTIVE DATE.**—(A) Subject to subparagraph (B), the amendments made by paragraph (1) apply to services furnished in 1990 which were subject to the first sentence of section 1842(b)(4)(F) of the Social Security Act in 1989.

(B) The amendments made by paragraph (1) shall not apply to services furnished in 1990 before April 1, 1990. With respect to physicians’ services furnished during 1990 on and after April 1, such amendments shall be applied as though any reference, in the matter inserted by such amendments, to the “first calendar year during which the preceding sentence no longer applies” were deemed a reference to the remainder of 1990.

(b) **LIMITATION ON AMOUNTS FOR CERTAIN SERVICES FURNISHED BY MORE THAN ONE SPECIALTY.**—

(1) *IN GENERAL.*—Section 1842(b) of such Act (42 U.S.C. 1395u(b)), as amended by section 6102(a) of this subtitle, is amended by adding at the end the following:

“(15)(A) In determining the reasonable charge for surgery, radiology, and diagnostic physicians’ services which the Secretary shall designate (based on their high volume of expenditures under this part) and for which the prevailing charge (but for this paragraph) differs by physician specialty, the prevailing charge for such a service may not exceed the prevailing charge or fee schedule amount for that specialty of physicians that furnish the service most frequently nationally.

“(B) In the case of a reduction in the prevailing charge for a physicians’ service under subparagraph (A), if a nonparticipating physician furnishes the service to an individual entitled to benefits under this part, after the effective date of the reduction, the physician’s actual charge is subject to a limit under subsection (j)(1)(D).”

(2) *SPECIAL LIMITS ON ACTUAL CHARGES.*—Section 1842(j)(1)(D) of such Act (42 U.S.C. 1395u(j)(1)(D)) is amended—

(A) in clause (ii)(IV), by inserting “or (b)(15)(A)” before the comma at the end, and

(B) in clause (iii)(II), by striking “or (b)(14)(A)” and inserting “(b)(14)(A), or (b)(15)(A)”.

(3) *EFFECTIVE DATE.*—The amendments made by this subsection apply to procedures performed after March 31, 1990.

SEC. 6109. WAIVER OF LIABILITY LIMITING RECOUPMENT IN CERTAIN CASES.

In the case where more than the correct amount may have been paid to a physician or individual under part B of title XVIII of the Social Security Act with respect to services furnished during the period beginning on July 1, 1985, and ending on March 31, 1986, as a result of a carrier’s establishing statewide fees for certain procedure codes while the carrier was in the process of implementing the national common procedure coding system of the Health Care Financing Administration, the provisions of section 1870(c) of the Social Security Act shall apply, without the need for affirmative action by such a physician or individual, so as to prevent any recoupment, or other decrease in subsequent payments, to the physician or individual. The previous sentence shall apply to claims for items and services which were reopened by carriers on or after July 31, 1987.

SEC. 6110. REDUCTION IN CAPITAL PAYMENTS FOR OUTPATIENT HOSPITAL SERVICES.

Section 1861(v)(1)(S) of the Social Security Act (42 U.S.C. 1395x(v)(1)(S)) is amended—

(1) by inserting “(i)” after “(S)”, and

(2) by adding at the end the following new clause:

“(ii)(I) Such regulations shall provide that, in determining the amount of the payments that may be made under this title with respect to all the capital-related costs of outpatient hospital services, the Secretary shall reduce the amounts of such payments otherwise established under this title by 15 percent for payments attributable to portions of cost reporting periods occurring during fiscal year 1990.

“(II) Subclause (I) shall not apply to payments with respect to the capital-related costs of any hospital that is a sole community hospital (as defined in section 1886(d)(5)(C)(ii)).

“(III) In applying subclause (I) to services for which payment is made on the basis of a blend amount under section 1833(i)(3)(A)(ii) or 1833(n)(1)(A)(ii), capital-related costs reflected in the amounts described in sections 1833(i)(3)(B)(i)(I) and 1833(n)(1)(B)(i)(I), respectively, shall be reduced in accordance with such subclause.”.

SEC. 6111. CLINICAL DIAGNOSTIC LABORATORY TESTS.

(a) **REDUCTION OF LIMITATION AMOUNT ON PAYMENT AMOUNT.**—Section 1833(h) of the Social Security Act (42 U.S.C. 1395l(h)) is amended—

(1) in subparagraphs (B) and (C) of paragraph (1), by striking “during the period” and all that follows through “established on a nationwide basis” and inserting “on or after July 1, 1984”;

(2) in paragraph (4)(B)(i), by striking “or” at the end;

(3) in paragraph (4)(B)(ii)—

(A) by striking “and so long as a fee schedule for the test has not been established on a nationwide basis,”

(B) by inserting “and before January 1, 1990,” after “March 31, 1988,” and

(C) by striking the period at the end and inserting “, and”; and

(4) by adding at the end of paragraph (4)(B) the following new clause:

“(iii) after December 31, 1989, is equal to 93 percent of the median of all the fee schedules established for that test for that laboratory setting under paragraph (1).”.

(b) **RESTRICTION ON PAYMENT TO REFERRING LABORATORY.**—

(1) **IN GENERAL.**—Section 1833(h)(5)(A)(ii) of such Act (42 U.S.C. 1395l(h)(5)(A)(ii)) is amended by striking “referring laboratory, and” and inserting “referring laboratory but only if—

“(I) the referring laboratory is located in, or is part of, a rural hospital,

“(II) the referring laboratory is a wholly-owned subsidiary of the entity performing such test, the referring laboratory wholly owns the entity performing such test, or both the referring laboratory and the entity performing such test are wholly-owned by a third entity, or

“(III) not more than 30 percent of the clinical diagnostic laboratory tests for which such referring laboratory submits bills or requests for payment in any year are performed by another laboratory, and”.

(2) **EFFECTIVE DATE.**—The amendment made by paragraph (1) shall apply with respect to clinical diagnostic laboratory tests performed on or after January 1, 1990.

SEC. 6112. DURABLE MEDICAL EQUIPMENT.

(a) **DELAY IN AND REDUCTION OF UPDATE FOR 1990.**—

(1) **INEXPENSIVE AND ROUTINELY PURCHASED DURABLE MEDICAL EQUIPMENT AND ITEMS REQUIRING FREQUENT AND SUBSTANTIAL SERVICING.**—Paragraphs (2)(B)(i) and (3)(B)(i) of section 1834(a) of the Social Security Act (42 U.S.C. 1395m(a)) are each

amended by striking "in 1989" and inserting "in 1989 and in 1990".

(2) MISCELLANEOUS DEVICES AND ITEMS AND OTHER COVERED ITEMS.—Paragraph (8)(A)(ii) of such section is amended—

(A) in subclause (I), by striking "1989" and inserting "1989 and 1990", and

(B) in subclause (II), by striking "1990, 1991," and inserting "1991".

(3) OXYGEN AND OXYGEN EQUIPMENT.—Paragraph (9)(A)(ii) of such section is amended—

(A) in subclause (I), by striking "1989" and inserting "1989 and 1990", and

(B) in subclause (II), by striking "1990, 1991," and inserting "1991".

(4) CONFORMING AMENDMENTS.—Such section is further amended—

(A) in paragraph (7)(A)(i), by striking "this subparagraph" and inserting "this clause";

(B) in paragraph (7)(B)(i), by inserting "in" after "rental of the item"; and

(C) in paragraph (7)(B)(ii), by striking "the payment amount" and all that follows and inserting "clause (i) shall apply in the same manner as it applies to items furnished during 1989.".

(b) RENTAL PAYMENTS FOR ENTERAL AND PARENTERAL PUMPS.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amount of any monthly rental payment under part B of title XVIII of the Social Security Act for an enteral or parenteral pump furnished on or after April 1, 1990, shall be determined in accordance with the methodology under which monthly rental payments for such pumps were determined during 1989.

(2) CAP ON RENTAL PAYMENTS, SERVICING, AND REPAIRS.—In the case of an enteral or parenteral pump described in paragraph (1) that is furnished on a rental basis during a period of medical need—

(A) monthly rental payments shall not be made under part B of title XVIII of the Social Security Act for more than 15 months during such period, and

(B) after monthly rental payments have been made for 15 months during such period, payment under such part shall be made for maintenance and servicing of the pump in such amounts as the Secretary of Health and Human Services determines to be reasonable and necessary to ensure the proper operation of the pump.

(c) REDUCTION IN FEE SCHEDULES FOR SEAT-LIFT CHAIRS AND TRANSCUTANEOUS ELECTRICAL NERVE STIMULATORS.—Paragraph (1) of such section is amended by adding at the end the following new subparagraph:

"(D) REDUCTION IN FEE SCHEDULES FOR CERTAIN ITEMS.—With respect to a seat-lift chair or transcutaneous electrical nerve stimulator furnished on or after April 1, 1990, the Secretary shall reduce the payment amount applied under subparagraph (B)(ii) for such an item by 15 percent."

(d) TREATMENT OF POWER DRIVEN WHEELCHAIRS.—

(1) *AS ROUTINELY PURCHASED.*—Section 1834(a)(2)(A) of the Social Security Act (42 U.S.C. 1395m(a)(2)(A)) is amended—

(A) by striking “or” at the end of clause (i),

(B) by adding “or” at the end of clause (ii), and

(C) by inserting after clause (ii) the following new clause:

“(iii) which is a power-driven wheelchair (other than a customized wheelchair that is classified as a customized item under paragraph (4) pursuant to criteria specified by the Secretary),”.

(2) *AS CUSTOMIZED ITEM.*—The Secretary of Health and Human Services shall by regulation specify criteria to be used by carriers in making determinations on a case-by-case basis as whether to classify power-driven wheelchairs as a customized item (as described in section 1834(a)(4) of the Social Security Act) for purposes of reimbursement under title XVIII of such Act.

(e) *OSTOMY SUPPLIES AS PART OF HOME HEALTH SERVICES.*—

(1) *SPECIFIC INCLUSION IN HOME HEALTH SERVICES.*—Section 1861(m)(5) of the Social Security Act (42 U.S.C. 1395x(m)(5)) is amended to read as follows:

“(5) medical supplies (including catheters, catheter supplies, ostomy bags, and supplies related to ostomy care, but excluding drugs and biologicals) and durable medical equipment while under such a plan;”.

(2) *EXCLUSION FROM COVERED ITEMS.*—Section 1834(a)(13) of such Act (42 U.S.C. 1395m(a)(13)) is amended by inserting after “intraocular lenses” the following: “or medical supplies (including catheters, catheter supplies, ostomy bags, and supplies related to ostomy care) furnished by a home health agency under section 1861(m)(5)”.

(3) *REQUIRING PROVISION AS PART OF HOME HEALTH SERVICES.*—Section 1866(a)(1) of such Act (42 U.S.C. 1395cc(a)(1)) is amended—

(A) by striking “and” at the end of subparagraph (N),

(B) by striking the period at the end of subparagraph (O) and inserting “; and”,

(C) and by inserting after subparagraph (O) the following new subparagraph:

“(P) in the case of home health agencies which provide home health services to individuals entitled to benefits under this title who require ostomy supplies (described in section 1861(m)(5)), to offer to furnish such supplies to such individual as part of their furnishing of home health services.”.

(4) *EFFECTIVE DATE.*—The amendments made by this subsection shall apply with respect to items furnished on or after January 1, 1990.

SEC. 6113. MENTAL HEALTH SERVICES.

(a) *ELIMINATING RESTRICTION ON PSYCHOLOGISTS’ SERVICES TO SERVICES FURNISHED AT COMMUNITY MENTAL HEALTH CENTERS.*—Section 1861(ii) of the Social Security Act (42 U.S.C. 1395x(ii)) is amended by striking “on-site at a community mental health center” and all that follows through “because of similar circumstances of the individual,”

(b) *CLINICAL SOCIAL WORKERS.*—

(1) *COVERAGE OF SERVICES.*—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) is amended—

(A) by striking “and” at the end of subparagraph (L);

(B) by adding “and” at the end of subparagraph (M); and

(C) by adding at the end the following new subparagraph:

“(N) clinical social worker services (as defined in subsection (hh)(2));”.

(2) *DEFINITIONS.*—Section 1861 of such Act (42 U.S.C. 1395x) is amended—

(A) in subsection (s)(2)(H)(ii), by striking “(hh)” and inserting “(hh)(2)”, and

(B) in subsection (hh)—

(i) by amending the heading to read as follows:

“Clinical Social Worker; Clinical Social Worker Services”,

(ii) by redesignating clauses (i) and (ii) of paragraph (3)(B) as subclauses (I) and (II), respectively,

(iii) by redesignating subparagraphs (A) and (B) of paragraph (3) as clauses (i) and (ii), respectively,

(iv) by redesignating paragraphs (1), (2), and (3) as subparagraphs (A), (B), and (C), respectively,

(v) by striking “(hh)” and inserting “(hh)(1)”, and

(vi) by adding at the end the following new paragraph:

“(2) The term ‘clinical social worker services’ means services performed by a clinical social worker (as defined in paragraph (1)) for the diagnosis and treatment of mental illnesses (other than services furnished to an inpatient of a hospital and other than services furnished to an inpatient of a skilled nursing facility which the facility is required to provide as a requirement for participation) which the clinical social worker is legally authorized to perform under State law (or the State regulatory mechanism provided by State law) of the State in which such services are performed as would otherwise be covered if furnished by a physician or as an incident to a physician’s professional service.”.

(3) *PAYMENT BASIS.*—Section 1833 of such Act (42 U.S.C. 1395l) is amended—

(A) by inserting after clause (E) of subsection (a)(1) the following new clause: “(F) with respect to clinical social worker services under section 1861(s)(2)(N), the amounts paid shall be 80 percent of the lesser of (i) the actual charge for the services or (ii) 75 percent of the amount determined for payment of a psychologist under clause (L),”; and

(B) in subsection (p)—

(i) by striking “1861(s)(2)(L) and” and by inserting “1861(s)(2)(L),”, and

(ii) by inserting “and in the case of clinical social worker services for which payment may be made under this part only pursuant to section 1861(s)(2)(N),” after “1861(s)(2)(M),”.

(c) *DEVELOPMENT OF CRITERIA REGARDING CONSULTATION WITH A PHYSICIAN.*—The Secretary of Health and Human Services shall, taking into consideration concerns for patient confidentiality, develop criteria with respect to payment for qualified psychologist services for which payment may be made directly to the psychologist under part B of title XVIII of the Social Security Act under which such a psychologist must agree to consult with a patient's attending physician in accordance with such criteria.

(d) *ELIMINATING DOLLAR LIMITATION ON MENTAL HEALTH SERVICES.*—Section 1833(d)(1) of the Social Security Act (42 U.S.C. 1395l(d)(1)) is amended by striking "whichever" and all that follows and inserting "62½ percent of such expenses."

(e) *EFFECTIVE DATE.*—The amendments made by this section, and the provisions of subsection (c), shall apply to services furnished on or after July 1, 1990, and the amendments made by subsection (d) shall apply to expenses incurred in a year beginning with 1990.

SEC. 6114. COVERAGE OF NURSE PRACTITIONER SERVICES IN NURSING FACILITIES.

(a) *SERVICES COVERED.*—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) is amended—

(1) by striking "and" at the end of subparagraph (J), and

(2) in subparagraph (K)—

(A) in clause (i), by striking "and" at the end,

(B) in clause (ii), by striking "to such services" and inserting "to services described in clause (i) or (ii)",

(C) by redesignating clause (ii) as clause (iii), and

(D) by inserting after clause (i) the following new clause:

"(ii) services which would be physicians' services if furnished by a physician (as defined in subsection (r)(1)) and which are performed by a nurse practitioner (as defined in subsection (aa)(3)) working in collaboration (as defined in subsection (aa)(4)) with a physician (as defined in subsection (r)(1)) in a skilled nursing facility or nursing facility (as defined in section 1919(a)) which the nurse practitioner is legally authorized to perform by the State in which the services are performed, and".

(b) *DETERMINATION OF PAYMENT AMOUNT.*—Section 1842(b)(12)(A) of such Act (42 U.S.C. 1395u(b)(12)(A)) is amended by striking "physician assistant acting under the supervision of a physician" and inserting "physician assistants and nurse practitioners".

(c) *PAYMENT TO EMPLOYER; PAYMENT FOR ROUTINE VISITS BY MEMBERS OF A TEAM.*—Section 1842(b) of such Act (42 U.S.C. 1395u(b)) is amended—

(1) in clause (C) of the first sentence of paragraph (6), by inserting "or nurse practitioner" after "physician assistant", and

(2) by adding at the end of paragraph (2), the following new subparagraph:

"(C) In the case of residents of nursing facilities who receive services described in clause (i) or (ii) of section 1861(s)(2)(K) performed by a member of a team, the Secretary shall instruct carriers to develop mechanisms which permit routine payment under this part for up to 1.5 visits per month per resident. In the previous sentence, the term 'team' refers to a physician and includes a physician assistant

acting under the supervision of the physician or a nurse practitioner working in collaboration with that physician, or both.”.

(d) **DEFINITION OF COLLABORATION.**—Section 1861(aa) of such Act (42 U.S.C. 1395x(aa)) is amended by adding at the end the following new paragraph:

“(4) The term ‘collaboration’ means a process in which a nurse practitioner works with a physician to deliver health care services within the scope of the practitioner’s professional expertise, with medical direction and appropriate supervision as provided for in jointly developed guidelines or other mechanisms as defined by the law of the State in which the services are performed.”.

(e) **STATE DEMONSTRATION PROJECTS ON APPLICATION OF LIMITATION ON VISITS PER MONTH PER RESIDENT ON AGGREGATE BASIS FOR A TEAM.**—The Secretary of Health and Human Services shall provide for at least 1 demonstration project under which, in the application of section 1842(b)(2)(C) of the Social Security Act (as added by subsection (c)(2) of this section) in one or more States, the limitation on the number of visits per month per resident would be applied on an average basis over the aggregate total of residents receiving services from members of the team.

(f) **EFFECTIVE DATE.**—The amendments made by this section shall apply to services furnished on or after April 1, 1990.

SEC. 6115. COVERAGE OF SCREENING PAP SMEARS.

(a) **IN GENERAL.**—Section 1861 of the Social Security Act (42 U.S.C. 1395x), as amended by section 6003(g)(3)(A) of this subtitle, is amended—

(1) in subsection (s)—

(A) by striking “and” at the end of paragraph (12),

(B) by striking the period at the end of paragraph (13) and inserting “; and”,

(C) by redesignating paragraphs (14) and (15) as paragraphs (15) and (16), respectively, and

(D) by inserting after paragraph (13) the following new paragraph;

“(14) screening pap smear.”; and

(2) by adding at the end the following new subsection:

“Screening Pap Smear

“(nn) The term ‘screening pap smear’ means a diagnostic laboratory test consisting of a routine exfoliative cytology test (Papanicolaou test) provided to a woman for the purpose of early detection of cervical cancer and includes a physician’s interpretation of the results of the test, if the individual involved has not had such a test during the preceding 3 years (or such shorter period as the Secretary may specify in the case of a woman who is at high risk of developing cervical cancer (as determined pursuant to factors identified by the Secretary)).”.

(b) **REVISION OF EXCLUSION GROUNDS.**—Section 1862(a)(1)(F) of such Act (42 U.S.C. 1395y(a)(1)(F)) is amended by inserting before the semicolon at the end the following: “, and, in the case of screening pap smear, which is performed more frequently than is provided under 1861(nn)”.

(c) **CONFORMING AMENDMENTS.**—Sections 1864(a), 1865(a), 1902(a)(9)(C), and 1915(a)(1)(B)(ii)(I) of such Act (42 U.S.C. 1395aa(a), 1395bb(a), 1396(a)(9)(C), 1396n(a)(1)(B)(ii)(I)) are each amended by striking “paragraphs (14) and (15)” and inserting “paragraphs (15) and (16)”.

(d) **EFFECTIVE DATE.**—The amendments made by this section shall apply to screening pap smears performed on or after July 1, 1990.

SEC. 6116. COVERAGE UNDER, AND PAYMENT FOR, OUTPATIENT RURAL PRIMARY CARE HOSPITAL SERVICES UNDER PART B.

(a) **COVERAGE.**—

(1) Section 1861(mm) of the Social Security Act (42 U.S.C. 1395x(mm)), as added by section 6003(g)(3)(A) of this subtitle, is amended by adding at the end the following:

“(3) The term ‘outpatient rural primary care hospital services’ means medical and other health services furnished by a rural primary care hospital.”.

(2) Section 1832(a)(2) of such Act (42 U.S.C. 1395k(a)(2)) is amended—

(A) in subparagraph (F), by striking “and” at the end,

(B) in subparagraph (G) by striking the period at the end and inserting “; and”, and

(C) by inserting after subparagraph (G) the following new subparagraph:

“(H) outpatient rural primary care hospital services (as defined in section 1861(mm)(3)).”.

(b) **PAYMENT.**—

(1) Section 1833(a) of such Act (42 U.S.C. 1395l(a)) is amended—

(A) in paragraph (2), in the matter before subparagraph (A), by striking “and (G)” and inserting “(G), and (H)”,

(B) in paragraph (4), by striking “and” at the end,

(C) in paragraph (5), by striking the period at the end and inserting “; and”, and

(D) by inserting after paragraph (5) the following new paragraph:

“(6) in the case of outpatient rural primary care hospital services, the amounts described in section 1834(f).”.

(2) Section 1834 of such Act (42 U.S.C. 1395m) is amended by adding at the end the following new subsection:

“(f) PAYMENT FOR OUTPATIENT RURAL PRIMARY CARE HOSPITAL SERVICES.—

“(1) **IN GENERAL.**—The amount of payment for outpatient rural primary care hospital services provided during a year before 1993 in a rural primary care hospital under this part shall be determined by one of the 2 following methods, as elected by the rural primary care hospital:

“(A) **COST-BASED FACILITY FEE PLUS PROFESSIONAL CHARGES.**—

“(i) **FACILITY FEE.**—With respect to facility services, not including any services for which payment may be made under clause (ii), there shall be paid amounts equal to the amounts described in section 1833(a)(2)(B)

(describing amounts paid for hospital outpatient services).

“(ii) **REASONABLE CHARGES FOR PROFESSIONAL SERVICES.**—In electing treatment under this subparagraph, payment for professional medical services otherwise included within outpatient rural primary care hospital services shall be made under such other provisions of this part as would apply to payment for such services if they were not included in outpatient rural primary care hospital services.

“(B) **ALL-INCLUSIVE RATE.**—With respect to both facility services and professional medical services, there shall be paid amounts equal to the costs which are reasonable and related to the cost of furnishing such services or which are based on such other tests of reasonableness as the Secretary may prescribe in regulations, less the amount the hospital may charge as described in clause (i) of section 1866(a)(2)(A), but in no case may the payment for such services (other than for items and services described in section 1861(s)(10)(A) and for items and services furnished in connection with obtaining a second opinion required under section 1164(c)(2), or a third opinion, if the second opinion was in disagreement with the first opinion) exceed 80 percent of such costs.

“(2) **DEVELOPMENT AND IMPLEMENTATION OF ALL INCLUSIVE, PROSPECTIVE PAYMENT SYSTEM.**—Not later than January 1, 1993, the Secretary shall develop and implement a prospective payment system for determining payments under this part for outpatient rural primary care hospital services using a methodology that includes all costs in providing all such services (including related professional medical services) and that determines the payment amount for such services on a prospective basis.”.

Subpart B—Technical and Miscellaneous Provisions

SEC. 6131. MODIFICATION OF PAYMENT FOR THERAPEUTIC SHOES FOR INDIVIDUALS WITH SEVERE DIABETIC FOOT DISEASE.

(a) PERMITTING ADDITIONAL INSERTS.—

(1) **IN GENERAL.**—Section 1833(o) of the Social Security Act (42 U.S.C. 1395l(o)) is amended—

(A) by amending subparagraph (A) of paragraph (1) to read as follows:

“(A) no payment may be made under this part, with respect to any individual for any year, for the furnishing of—

“(i) more than one pair of custom molded shoes (including inserts provided with such shoes) and 2 additional pairs of inserts for such shoes, or

“(ii) more than one pair of extra-depth shoes (not including inserts provided with such shoes) and 3 pairs of inserts for such shoes, and”;

(B) in paragraphs (1)(B) and (2)(A), by striking “limit” and inserting “limits”;

(C) in the second sentence of paragraph (1), by inserting “(or inserts)” after “shoes” each place it appears;

(D) by amending clause (i) of paragraph (2)(A) to read as follows:

“(i) for the furnishing of—

“(I) one pair of custom molded shoes (including any inserts that are provided initially with the shoes) is \$300, and

“(II) any additional pair of inserts with respect to such shoes is \$50; and”; and

(E) in paragraph (2)(A)(ii)(II), by inserting “any pairs of” after “\$50 for”.

(2) **CONFORMING AMENDMENT.**—Section 1861(s)(12) of such Act (42 U.S.C. 1395x(s)(12)) is amended by inserting “with inserts” after “custom molded shoes”.

(b) **PERMITTING SUBSTITUTION OF SHOE MODIFICATIONS FOR INSERTS.**—Section 1833(o)(2) of such Act is amended by adding at the end the following new subparagraph:

“(D) In accordance with procedures established by the Secretary, an individual entitled to benefits with respect to shoes described in section 1861(s)(12) may substitute modification of such shoes instead of obtaining one (or more, as specified by the Secretary) pairs of inserts (other than the original pair of inserts with respect to such shoes). In such case, the Secretary shall substitute, for the limits established under subparagraph (A), such limits as the Secretary estimates will assure that there is no net increase in expenditures under this subsection as a result of this subparagraph.”.

(c) **EFFECTIVE DATE.**—

(1) The amendments made by this section shall apply with respect to therapeutic shoes and inserts furnished on or after July 1, 1989.

(2) In applying the amendments made by this section, the increase under subparagraph (C) of section 1833(o)(2) of the Social Security Act shall apply to the dollar amounts specified under subparagraph (A) of such section (as amended by this section) in the same manner as the increase would have applied to the dollar amounts specified under subparagraph (A) of such section (as in effect before the date of the enactment of this Act).

SEC. 6132. PAYMENTS TO CERTIFIED REGISTERED ANESTHETISTS.

(a) **EXTENSION AND EXPANSION OF CRNA PASS-THROUGH.**—Section 9320(k) of the Omnibus Budget Reconciliation Act of 1986, as added by section 608(c)(2) of the Family Support Act of 1988, is amended—

(1) by striking “250” each place it appears and inserting “500”;

(2) in paragraph (1)—

(A) by striking “1989, 1990, and 1991” and inserting “a year (beginning with 1989)”, and

(B) by striking “before April 1, 1989,” and inserting “at any time before the year”;

(3) in paragraph (2)—

(A) by striking “1990 or 1991” and inserting “in a year (after 1989)”, and

(B) by striking “each respective year” and inserting “the year”; and

(4) by striking paragraph (3).

(b) **EFFECTIVE DATE.**—The amendments made by this section shall apply to services furnished on or after January 1, 1990.

SEC. 6133. INCREASE IN PAYMENT LIMIT FOR PHYSICAL AND OCCUPATIONAL THERAPY SERVICES.

(a) **IN GENERAL.**—Section 1833(g) of the Social Security Act (42 U.S.C 1395l(g)) is amended by striking “\$500” each place it appears and inserting “\$750”.

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall apply to services furnished on or after January 1, 1990.

SEC. 6134. STUDY OF PAYMENT FOR PORTABLE X-RAY SERVICES.

The Secretary of Health and Human Services shall conduct a study of the costs of furnishing, and payments for, portable x-ray services under part B of title XVIII of the Social Security Act. Not later than 1 year after the date of the enactment of this Act, the Secretary shall report to Congress on the results of such study and shall include a recommendation respecting whether payment for such services should be made in the same manner as for radiologists’ services or on the basis of a separate fee schedule.

SEC. 6135. EXTENSION OF MUNICIPAL HEALTH SERVICE DEMONSTRATION PROJECTS.

Section 9215 of the Consolidated Omnibus Budget Reconciliation Act of 1985 is amended—

(1) by striking “, for a period of three additional years,” and inserting “through December 31, 1993,”; and

(2) by adding at the end the following: “The Secretary shall submit a report to Congress on the waiver program with respect to the quality of health care, beneficiary costs, and such other factors as may be appropriate.”.

SEC. 6136. STUDY OF REIMBURSEMENT FOR AMBULANCE SERVICES.

(a) **IN GENERAL.**—The Secretary of Health and Human Services shall conduct a study to determine the adequacy and appropriateness of payment amounts under title XVIII of the Social Security Act for ambulance services. Such study shall examine at least the following:

(1) The effect of payment amounts on the provision of ambulance services in rural areas.

(2) The relationship of such payment amounts to the direct and indirect costs of providing ambulance services. Such relationship shall be examined separately—

(A)(i) for tax-subsidized, municipally-owned and operated services, (ii) for volunteer services, (iii) for private, for-profit services, and (iv) for hospital-owned services, and

(B) for different levels (such as basic life support and advanced life support) of such services.

(3) How such payment amounts compare to the payment amounts made for ambulance services under medicaid plans under title XIX of such Act.

(b) **REPORT.**—By not later than one year after the date of the enactment of this Act, the Secretary shall submit a report to Congress

on the results of the study conducted under subsection (a) and shall include in the report such recommendations for changes in medicare payment policy with respect to ambulance services as may be needed to ensure access by medicare beneficiaries to quality ambulance services in metropolitan and rural areas.

SEC. 6137. PROPAC STUDY OF PAYMENTS FOR SERVICES IN HOSPITAL OUTPATIENT DEPARTMENTS.

(a) **IN GENERAL.**—The Prospective Payment Assessment Commission shall conduct a study and submit a report to Congress by no later than July 1, 1990, on payment under title XVIII of the Social Security Act for hospital outpatient services. Such study shall include an examination of—

(1) the sources of growth in spending for hospital outpatient services;

(2) the differences between the costs of delivering services in a hospital outpatient department as opposed to providing similar services in other appropriate settings (including ambulatory surgery centers and physician offices);

(3) the effects on outpatient hospital costs of the step-down method used to allocate hospital capital between inpatient and outpatient departments and the extent to which hospital outpatient costs were affected by the implementation of the prospective payment system of payment for inpatient hospital services and by increased review of such services by peer review organizations; and

(4) alternative methods for reimbursing hospitals for services in outpatient departments under the medicare program, including prospective payment methods, fee schedules, and such other methods as the Commission may consider appropriate.

(b) **REPORTS.**—(1) By not later than July 1, 1990, the Commission shall submit a report to Congress on the study conducted under subsection (a) with respect to the portions of the study described in paragraphs (1), (2), and (3) of such subsection, and shall include in the report such recommendations as the Commission deems appropriate.

(2) By not later than March 1, 1991, the Commission shall submit a report to Congress on the study conducted under subsection (a) with respect to the portions of the study described in paragraph (4) of such subsection, and shall include in the report such recommendations as the Commission deems appropriate.

SEC. 6138. PHYSPRC STUDY OF PAYMENTS FOR ASSISTANTS AT SURGERY.

(a) **STUDY; CONTENTS.**—The Physician Payment Review Commission shall conduct a study of the payments made under title XVIII of the Social Security Act for assistants at surgery. Such study shall examine—

(1) the necessity and appropriateness of using an assistant at surgery;

(2) the use of physician and non-physician assistants at surgery;

(3) the appropriateness of providing for payments, and the appropriate level of payment, under title XVIII of the Social Security Act for assistants at surgery; and

(4) the effect of the amendments made by section 9338 of the Omnibus Budget Reconciliation Act of 1986 on the employment of registered nurses as assistants at surgery, and whether or not the reductions described in subsection (d) of such section have been implemented.

(b) *REPORT*.—By not later than April 1, 1991, the Commission shall submit a report to Congress on the study conducted under subsection (a), and shall include in the report such recommendations as it deems appropriate.

SEC. 6139. GAO STUDY OF STANDARDS FOR USE OF AND PAYMENT FOR ITEMS OF DURABLE MEDICAL EQUIPMENT.

(a) *STUDY*.—The Comptroller General shall conduct a study of the appropriate uses of items of durable medical equipment and of the appropriate criteria for making determinations of medical necessity under title XVIII of the Social Security Act for such items, with particular emphasis on items (including seat-lift chairs) that may be subject to abusive billing practices. Such study shall include an analysis of—

(1) the appropriate use of forms in making medical necessity determinations for items of durable medical equipment under such title; and

(2) procedures for identifying items of durable medical equipment that should no longer be covered under such title.

(b) *USE OF PANEL IN CONDUCTING STUDY*.—The Comptroller General shall conduct such study with a panel convened by the Comptroller General consisting of—

(1) specialists in the disciplines of orthopedic medicine, rehabilitation, arthritis, and geriatric medicine;

(2) representatives of consumer organizations; and

(3) representatives of carriers under the medicare program.

(c) *REPORT*.—Not later than April 1, 1991, the Comptroller General shall submit a report to the Committees on Ways and Means and Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate on the study conducted under subsection (a), and shall include in such report such recommendations as the Comptroller General deems appropriate.

SEC. 6140. NARROWING OF RANGE OF AMOUNTS RECOGNIZED FOR ITEMS OF DURABLE MEDICAL EQUIPMENT.

Paragraphs (8) and (9) of section 1834(a) of the Social Security Act (42 U.S.C. 1395m(a)) are each amended in subparagraph (D)—

(1) in clause (i), by striking “1991” and all that follows through “80 percent” and inserting “1991, may not exceed 125 percent, and may not be lower than 85 percent”; and

(2) in clause (ii), by striking “125 percent” and all that follows through “85 percent” and inserting “120 percent, and may not be lower than 90 percent”.

SEC. 6141. PHYSICIAN OFFICE LABS.

(a) *IN GENERAL*.—Section 1861(s) of the Social Security Act (42 U.S.C. 1395x(s)) is amended—

(1) in the matter following paragraph (13), by striking “which is independent” and all that follows through “per year,” and inserting the following: “, including a laboratory that is part of”;

(2) by redesignating paragraph (15) as subparagraph (B); and
 (3) by inserting immediately after paragraph (14) the following:

“(15)(A) meets the certification requirements under the Clinical Laboratory Improvement Act of 1988; and”.

(b) **EFFECTIVE DATE.**—The amendments made by subsection (a) shall take effect on the date of the enactment of this Act.

SEC. 6142. STUDY OF REIMBURSEMENT FOR BLOOD CLOTTING FACTOR FOR HEMOPHILIA PATIENTS.

The Secretary of Health and Human Services shall review the current methodology for reimbursing for blood clotting factor for hemophilia patients under part B of title XVIII of the Social Security Act and shall evaluate the effect of such methodology on the accessibility and affordability of such factor to medicare beneficiaries. By not later than 6 months after the date of the enactment of this Act, the Secretary shall report to the Committees on Energy and Commerce and Ways and Means of the House of Representatives and the Committee on Finance of the Senate on such review and shall include in such report such recommendations as the Secretary deems appropriate.

PART 3—PROVISIONS RELATING TO

PARTS A AND B

Subpart A—General Provisions

SEC. 6201. REDUCTIONS UNDER ORIGINAL SEQUESTER ORDER AND APPLICABILITY OF NEW SEQUESTER ORDER FOR HEALTH MAINTENANCE ORGANIZATIONS.

Notwithstanding any other provision of law (including section 11002 or any other provision of this Act), the reductions in the amount of payments required under title XVIII of the Social Security Act made by the final sequester order issued by the President on October 16, 1989, pursuant to section 252(b) of the Balanced Budget and Emergency Deficit Control Act of 1985 shall continue to be effective (as provided by sections 252(a)(4)(B) and 256(d)(2) of such Act) through December 31, 1989, with respect to payments under section 1833(a)(1)(A) or 1876 of the Social Security Act, section 402 of the Social Security Amendments of 1967, or section 222 of the Social Security Amendments of 1972. Each such payment made during fiscal year 1990 after such date shall be increased by 1.42 percent above what it would otherwise be under this Act.

SEC. 6202. MEDICARE AS SECONDARY PAYER.

(a) **IDENTIFICATION OF MEDICARE SECONDARY PAYER SITUATIONS.**—

(1) **DISCLOSURE OF CERTAIN TAXPAYER IDENTITY INFORMATION FOR VERIFICATION OF EMPLOYMENT STATUS OF MEDICARE BENEFICIARY AND SPOUSE OF MEDICARE BENEFICIARY.**—

(A) **IN GENERAL.**—Subsection (l) of section 6103 of the Internal Revenue Code of 1986 (relating to disclosure of returns and return information for purposes other than tax

administration) is amended by adding at the end thereof the following new paragraph:

"(12) DISCLOSURE OF CERTAIN TAXPAYER IDENTITY INFORMATION FOR VERIFICATION OF EMPLOYMENT STATUS OF MEDICARE BENEFICIARY AND SPOUSE OF MEDICARE BENEFICIARY.—

"(A) RETURN INFORMATION FROM INTERNAL REVENUE SERVICE.—The Secretary shall, upon written request from the Commissioner of Social Security, disclose to the Commissioner available filing status and taxpayer identity information from the individual master files of the Internal Revenue Service relating to whether any medicare beneficiary identified by the Commissioner was a married individual (as defined in section 7703) for any specified year after 1986, and, if so, the name of the spouse of such individual and such spouse's TIN.

"(B) RETURN INFORMATION FROM SOCIAL SECURITY ADMINISTRATION.—The Commissioner of Social Security shall, upon written request from the Administrator of the Health Care Financing Administration, disclose to the Administrator the following information:

"(i) The name and TIN of each medicare beneficiary who is identified as having received wages (as defined in section 3401(a)) from a qualified employer in a previous year.

"(ii) For each medicare beneficiary who was identified as married under subparagraph (A) and whose spouse is identified as having received wages from a qualified employer in a previous year—

"(I) the name and TIN of the medicare beneficiary, and

"(II) the name and TIN of the spouse.

"(iii) With respect to each such qualified employer, the name, address, and TIN of the employer and the number of individuals with respect to whom written statements were furnished under section 6051 by the employer with respect to such previous year.

"(C) DISCLOSURE BY HEALTH CARE FINANCING ADMINISTRATION.—With respect to the information disclosed under subparagraph (B), the Administrator of the Health Care Financing Administration may disclose—

"(i) to the qualified employer referred to in such subparagraph the name and TIN of each individual identified under such subparagraph as having received wages from the employer (hereinafter in this subparagraph referred to as the 'employee') for purposes of determining during what period such employee or the employee's spouse may be (or have been) covered under a group health plan of the employer and what benefits are or were covered under the plan (including the name, address, and identifying number of the plan),

"(ii) to any group health plan which provides or provided coverage to such an employee or spouse, the name of such employee and the employee's spouse (if the spouse is a medicare beneficiary) and the name and ad-

dress of the employer, and, for the purpose of presenting a claim to the plan—

“(I) the TIN of such employee if benefits were paid under title XVIII of the Social Security Act with respect to the employee during a period in which the plan was a primary plan (as defined in section 1862(b)(2)(A) of the Social Security Act), and

“(II) the TIN of such spouse if benefits were paid under such title with respect to the spouse during such period, and

“(iii) to any agent of such Administrator the information referred to in subparagraph (B) for purposes of carrying out clauses (i) and (ii) on behalf of such Administrator.

“(D) SPECIAL RULES.—

“(i) RESTRICTIONS ON DISCLOSURE.—Information may be disclosed under this paragraph only for purposes of, and to the extent necessary in, determining the extent to which any medicare beneficiary is covered under any group health plan.

“(ii) TIMELY RESPONSE TO REQUESTS.—Any request made under subparagraph (A) or (B) shall be complied with as soon as possible but in no event later than 120 days after the date the request was made.

“(E) DEFINITIONS.—For purposes of this paragraph—

“(i) MEDICARE BENEFICIARY.—The term ‘medicare beneficiary’ means an individual entitled to benefits under part A, or enrolled under part B, of title XVIII of the Social Security Act, but does not include such an individual enrolled in part A under section 1818.

“(ii) GROUP HEALTH PLAN.—The term ‘group health plan’ means—

“(I) any group health plan (as defined in section 5000(b)(1)), and

“(II) any large group health plan (as defined in section 5000(b)(2)).

“(iii) QUALIFIED EMPLOYER.—The term ‘qualified employer’ means, for a calendar year, an employer which has furnished written statements under section 6051 with respect to at least 20 individuals for wages paid in the year.

“(F) TERMINATION.—Subparagraphs (A) and (B) shall not apply to—

“(i) any request made after September 30, 1991, and

“(ii) any request made before such date for information relating to—

“(I) 1990 or thereafter in the case of subparagraph (A), or

“(II) 1991 or thereafter in the case of subparagraph (B).”

(B) SAFEGUARDS.—

(i) Paragraph (3) of section 6103(a) of such Code is amended by inserting “(l)(12),” after “(e)(1)(D)(iii),”.

(ii) Subparagraph (A) of section 6103(p)(3) of such Code is amended by striking "or (11)" and inserting "(11), or (12)".

(iii) Paragraph (4) of section 6103(p) of such Code is amended in the material preceding subparagraph (A) by striking "or (9) shall" and inserting "(9), or (12) shall".

(iv) Clause (ii) of section 6103(p)(4)(F) of such Code is amended by striking "or (11)" and inserting "(11), or (12)".

(v) The next to the last sentence of paragraph (4) of section 6103(p) of such Code is amended by inserting "or which receives any information under subsection (l)(12)(B) and which discloses any such information to any agent" before ", this paragraph".

(C) **PENALTY.**—Paragraph (2) of section 7213(a) of such Code is amended by striking "or (10)" and inserting "(10), or (12)".

(D) **EFFECTIVE DATE.**—The amendments made by this paragraph shall take effect on the date of the enactment of this Act.

(2) **RESPONSIBILITIES OF HCFA.**—

(A) **IN GENERAL.**—Section 1862(b) of the Social Security Act (42 U.S.C. 1395y(b)), as amended by subsection (b)(1) of this section, is amended by inserting after paragraph (4) the following new paragraph:

"(5) **IDENTIFICATION OF SECONDARY PAYER SITUATIONS.**—

"(A) **REQUESTING MATCHING INFORMATION.**—

"(i) **COMMISSIONER OF SOCIAL SECURITY.**—The Commissioner of Social Security shall, not less often than annually, transmit to the Secretary of the Treasury a list of the names and TINs of medicare beneficiaries (as defined in section 6103(l)(12) of the Internal Revenue Code of 1986) and request that the Secretary disclose to the Commissioner the information described in subparagraph (A) of such section.

"(ii) **ADMINISTRATOR.**—The Administrator of the Health Care Financing Administration shall request, not less often than annually, the Commissioner of the Social Security Administration to disclose to the Administrator the information described in subparagraph (B) of section 6103(l)(12) of the Internal Revenue Code of 1986.

"(B) **DISCLOSURE TO FISCAL INTERMEDIARIES AND CARRIERS.**—In addition to any other information provided under this title to fiscal intermediaries and carriers, the Administrator shall disclose to such intermediaries and carriers (or to such a single intermediary or carrier as the Secretary may designate) the information received under subparagraph (A) for the purposes of carrying out this subsection.

"(C) **CONTACTING EMPLOYERS.**—

"(i) **IN GENERAL.**—With respect to each individual (in this subparagraph referred to as an 'employee') who was furnished a written statement under section 6051

of the Internal Revenue Code of 1986 by a qualified employer (as defined in section 6103(l)(12)(D)(iii) of such Code), as disclosed under subparagraph (B), the appropriate fiscal intermediary or carrier shall contact the employer in order to determine during what period the employee or employee's spouse may be (or have been) covered under a group health plan of the employer and the nature of the coverage that is or was provided under the plan (including the name, address, and identifying number of the plan).

“(ii) **EMPLOYER RESPONSE.**—Within 30 days of the date of receipt of the inquiry, the employer shall notify the intermediary or carrier making the inquiry as to the determinations described in clause (i). An employer (other than a Federal or other governmental entity) who willfully or repeatedly fails to provide timely and accurate notice in accordance with the previous sentence shall be subject to a civil money penalty of not to exceed \$1,000 for each individual with respect to which such an inquiry is made. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

“(iii) **SUNSET ON REQUIREMENT.**—Clause (ii) shall not apply to inquiries made after September 30, 1991.”

(B) **DEADLINE FOR FIRST REQUEST.**—The Commissioner of Social Security shall first—

(i) transmit to the Secretary of the Treasury information under paragraph (5)(A)(i) of section 1862(b) of the Social Security Act (as inserted by subparagraph (A)), and

(ii) request from the Secretary disclosure of information described in section 6013(l)(12)(A) of the Internal Revenue Code of 1986,

by not later than 14 days after the date of the enactment of this Act.

(b) **UNIFORM ENFORCEMENT AND COORDINATION OF BENEFITS.**—

(1) **IN GENERAL.**—Section 1862 of the Social Security Act (42 U.S.C. 1395y) is amended—

(A) in the heading, by adding at the end the following: “AND MEDICARE AS SECONDARY PAYER”; and

(B) by amending subsection (b) to read as follows:

“(b) **MEDICARE AS SECONDARY PAYER.**—

“(1) **REQUIREMENTS OF GROUP HEALTH PLANS.**—

“(A) **WORKING AGED UNDER GROUP HEALTH PLANS.**—

“(i) **IN GENERAL.**—A group health plan—

“(I) may not take into account, for any item or service furnished to an individual 65 years of age or older at the time the individual is covered under the plan by reason of the current employment of the individual (or the individual's spouse), that the individual is entitled to benefits under this title under section 226(a), and

“(II) shall provide that any employee aged 65 or older, and any employee’s spouse age 65 or older, shall be entitled to the same benefits under the plan under the same conditions as any employee, and the spouse of such employee, under age 65.

“(ii) EXCLUSION OF GROUP HEALTH PLAN OF A SMALL EMPLOYER.—Clause (i) shall not apply to a group health plan unless the plan is sponsored by or contributed to by an employer that has 20 or more employees for each working day in each of 20 or more calendar weeks in the current calendar year or the preceding calendar year.

“(iii) EXCEPTION FOR SMALL EMPLOYERS IN MULTIEMPLOYER OR MULTIPLE EMPLOYER GROUP HEALTH PLANS.—Clause (i) also shall not apply with respect to individuals enrolled in a multiemployer or multiple employer group health plan if the coverage of the individuals under the plan is by virtue of employment with an employer that does not have 20 or more employees for each working day in each of 20 or more calendar weeks in the current calendar year or the preceding calendar year; except that the exception provided in this clause shall only apply if the plan elects treatment under this clause.

“(iv) EXCEPTION FOR INDIVIDUALS WITH END STAGE RENAL DISEASE.—Clause (i) shall not apply to an item or service furnished in a month to an individual if for the month the individual is, or would upon application be, entitled to benefits under section 226A.

“(v) GROUP HEALTH PLAN DEFINED.—In this subparagraph, and subparagraph (C), the term ‘group health plan’ has the meaning given such term in section 5000(b)(1) of the Internal Revenue Code of 1986.

“(B) DISABLED ACTIVE INDIVIDUALS IN LARGE GROUP HEALTH PLANS.—

“(i) IN GENERAL.—A large group health plan (as defined in clause (iv)(II)) may not take into account that an active individual (as defined in clause (iv)(I)) is entitled to benefits under this title under section 226(b).

“(ii) EXCEPTION FOR INDIVIDUALS WITH END STAGE RENAL DISEASE.—Clause (i) shall not apply to an item or service furnished in a month to an individual if for the month the individual is, or would upon application be, entitled to benefits under section 226A.

“(iii) SUNSET.—Clause (i) shall only apply to items and services furnished on or after January 1, 1987, and before January 1, 1992.

“(iv) DEFINITIONS.—In this subparagraph:

“(I) ACTIVE INDIVIDUAL.—The term ‘active individual’ means an employee (as may be defined in regulations), the employer, self-employed individual (such as the employer), an individual associated with the employer in a business relationship, or a member of the family of any of such persons.

“(II) LARGE GROUP HEALTH PLAN.—The term ‘large group health plan’ has the meaning given such term in section 5000(b)(2) of the Internal Revenue Code of 1986.

“(C) INDIVIDUALS WITH END STAGE RENAL DISEASE.—A group health plan (as defined in subparagraph (A)(v))—

“(i) may not take into account that an individual is entitled to benefits under this title solely by reason of section 226A during the 12-month period which begins with the earlier of—

“(I) the month in which a regular course of renal dialysis is initiated, or

“(II) in the case of an individual who receives a kidney transplant, the first month in which he would be eligible for benefits under part A (if he had filed an application for such benefits) under the provisions of section 226A(b)(1)(B); and

“(ii) may not differentiate in the benefits it provides between individuals having end stage renal disease and other individuals covered by such plan on the basis of the existence of end stage renal disease, the need for renal dialysis, or in any other manner; except that clause (ii) shall not prohibit a plan from taking into account that an individual is entitled to benefits under this title solely by reason of section 226A after the end of the 12-month period described in clause (i).

“(2) MEDICARE SECONDARY PAYER.—

“(A) IN GENERAL.—Payment under this title may not be made, except as provided in subparagraph (B), with respect to any item or service to the extent that—

“(i) payment has been made, or can reasonably be expected to be made, with respect to the item or service as required under paragraph (1), or

“(ii) payment has been made, or can reasonably be expected to be made promptly (as determined in accordance with regulations) under a workmen’s compensation law or plan of the United States or a State or under an automobile or liability insurance policy or plan (including a self-insured plan) or under no fault insurance.

In this subsection, the term ‘primary plan’ means a group health plan or large group health plan, to the extent that clause (i) applies, and a workmen’s compensation law or plan, an automobile or liability insurance policy or plan (including a self-insured plan) or under no fault insurance, to the extent that clause (ii) applies.

“(B) CONDITIONAL PAYMENT.—

“(i) PRIMARY PLANS.—Any payment under this title with respect to any item or service to which subparagraph (A) applies shall be conditioned on reimbursement to the appropriate Trust Fund established by this title when notice or other information is received that payment for such item or service has been or could be made under such subparagraph.

"(ii) ACTION BY UNITED STATES.—In order to recover payment under this title for such an item or service, the United States may bring an action against any entity which is required or responsible under this subsection to pay with respect to such item or service (or any portion thereof) under a primary plan (and may, in accordance with paragraph (3)(A) collect double damages against that entity), or against any other entity (including any physician or provider) that has received payment from that entity with respect to the item or service, and may join or intervene in any action related to the events that gave rise to the need for the item or service.

"(iii) SUBROGATION RIGHTS.—The United States shall be subrogated (to the extent of payment made under this title for such an item or service) to any right under this subsection of an individual or any other entity to payment with respect to such item or service under a primary plan.

"(iv) WAIVER OF RIGHTS.—The Secretary may waive (in whole or in part) the provisions of this subparagraph in the case of an individual claim if the Secretary determines that the waiver is in the best interests of the program established under this title.

"(3) ENFORCEMENT.—

"(A) PRIVATE CAUSE OF ACTION.—There is established a private cause of action for damages (which shall be in an amount double the amount otherwise provided) in the case of a primary plan which fails to provide for primary payment (or appropriate reimbursement) in accordance with such paragraphs (1) and (2)(A).

"(B) REFERENCE TO EXCISE TAX WITH RESPECT TO NON-CONFORMING GROUP HEALTH PLANS.—For provision imposing an excise tax with respect to nonconforming group health plans, see section 5000 of the Internal Revenue Code of 1986.

"(4) COORDINATION OF BENEFITS.—Where payment for an item or service by a primary plan is less than the amount of the charge for such item or service and is not payment in full, payment may be made under this title (without regard to deductibles and coinsurance under this title) for the remainder of such charge, but—

"(A) payment under this title may not exceed an amount which would be payable under this title for such item or service if paragraph (2)(A) did not apply; and

"(B) payment under this title, when combined with the amount payable under the primary plan, may not exceed—

"(i) in the case of an item or service payment for which is determined under this title on the basis of reasonable cost (or other cost-related basis) or under section 1886, the amount which would be payable under this title on such basis, and

"(ii) in the case of an item or service for which payment is authorized under this title on another basis—

“(I) the amount which would be payable under the primary plan (without regard to deductibles and coinsurance under such plan), or

“(II) the reasonable charge or other amount which would be payable under this title (without regard to deductibles and coinsurance under this title),

whichever is greater.”

(2) **ENFORCEMENT THROUGH EXCISE TAX.**—Section 5000 of the Internal Revenue Code of 1986 is amended—

(A) by striking “**LARGE**” in the heading;

(B) in subsection (a), by striking “large” each place it appears; and

(C) by amending subsections (b) and (c) to read as follows:

“(b) **GROUP HEALTH PLAN AND LARGE GROUP HEALTH PLAN.**—For purposes of this section—

“(1) **GROUP HEALTH PLAN.**—The term ‘group health plan’ means any plan of, or contributed to by, an employer (including a self-insured plan) to provide health care (directly or otherwise) to the employer’s employees, former employees, or the families of such employees or former employees.

“(2) **LARGE GROUP HEALTH PLAN.**—The term ‘large group health plan’ means a plan of, or contributed to by, an employer or employee organization (including a self-insured plan) to provide health care (directly or otherwise) to the employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families, that covers employees of at least one employer that normally employed at least 100 employees on a typical business day during the previous calendar year.

“(c) **NONCONFORMING GROUP HEALTH PLAN.**—For purposes of this section, the term ‘nonconforming group health plan’ means a group health plan or large group health plan that at any time during a calendar year does not comply with the requirements of subparagraphs (A) and (C) or subparagraph (B), respectively, of section 1862(b)(1) of the Social Security Act.”

(3) **REPEAL OF CERTAIN ALTERNATIVE ENFORCEMENT PROVISIONS.**—

(A) **DENIAL OF DEDUCTION FOR GROUP HEALTH PLANS.**—Subsection (i) of section 162 of such Code (relating to group health plans) is repealed.

(B) **CONFORMING AMENDMENT.**—Section 4980B(g)(2) of such Code is amended by striking “162(i)” and inserting “5000(b)(1)”.

(C) **AGE DISCRIMINATION IN EMPLOYMENT ACT.**—The Age Discrimination in Employment Act of 1967 is amended—

(i) by striking subsection (g) of section 4, and

(ii) in section 12(a), by striking “(except the provisions of section 4(g))”.

(4) **CLERICAL AND CONFORMING AMENDMENTS.**—

(A) Chapter 47 of the Internal Revenue Code of 1986 is amended—

(i) in the heading, by striking “**LARGE**”, and

(ii) in the table of sections, by striking “large”

(B) The item in the table of chapters of subtitle D of such Code relating to chapter 47 is amended by striking "large".

(C) Sections 1837(i) and 1839(b) of the Social Security Act (42 U.S.C. 1395p(i), 1395r(b)) are each amended by striking "1862(b)(3)(A)(iv)" and "1862(b)(4)(B)" each place each appears and inserting "1862(b)(1)(A)(vi)" and "1862(b)(1)(B)(iv)", respectively.

(5) **EFFECTIVE DATE.**—The amendments made by this subsection shall apply to items and services furnished after the date of the enactment of this Act.

(c) **SPECIAL ENROLLMENT PERIOD FOR DISABLED EMPLOYEES.**—

(1) **IN GENERAL.**—Section 1837(i) of the Social Security Act (42 U.S.C. 1395p(i)) is amended—

(A) in paragraph (1)—

(i) by striking subparagraph (A),

(ii) by redesignating subparagraphs (B) and (C) as subparagraphs (A) and (B), respectively, and

(iii) in the second sentence, by inserting "not described in the previous sentence" after "In the case of an individual"; and

(B) in paragraph (2)—

(i) in subparagraph (B)(i), by striking "(1)(B)" and inserting "(1)(A)",

(ii) by striking subparagraph (A),

(iii) by redesignating subparagraphs (B) through (D) as subparagraphs (A) and (C), respectively, and

(iv) in the second sentence, by inserting "not described in the previous sentence" after "In the case of an individual".

(2) **CONFORMING AMENDMENT.**—The second sentence of section 1839(b) of such Act (42 U.S.C. 1395r(b)) is amended by striking "during which the individual has attained the age of 65 and".

(3) **EFFECTIVE DATE.**—The amendments made by this subsection shall apply to enrollments occurring after, and premiums for months after, the second calendar quarter beginning after the date of the enactment of this Act.

(d) **NO MATCHING BASED ON PRIVATE ACTIVITIES REQUIRED IN FISCAL INTERMEDIARY AGREEMENTS AND CARRIER CONTRACTS.**—

(1) **FISCAL INTERMEDIARY AGREEMENTS.**—Section 1816(c)(1) of the Social Security Act (42 U.S.C. 1395h(c)(1)) is amended by adding at the end the following: "The Secretary may not require, as a condition of entering into or renewing an agreement under this section or under section 1871, that a fiscal intermediary match data obtained other than in its activities under this part with data used in the administration of this part for purposes of identifying situations in which the provisions of section 1862(b) may apply."

(2) **CARRIER CONTRACTS.**—Section 1842(b)(2)(A) of such Act (42 U.S.C. 1395u(b)(2)(A)) is amended by adding at the end the following: "The Secretary may not require, as a condition of entering into or renewing a contract under this section or under section 1871, that a carrier match data obtained other than in its activities under this part with data used in the administration

of this part for purposes of identifying situations in which section 1862(b) may apply.”

(3) *EFFECTIVE DATE.*—The amendments made by this subsection shall apply to agreements and contracts entered into or renewed on or after the date of the enactment of this Act.

(e) *TREATMENT OF EMPLOYMENT AS A MEMBER OF A RELIGIOUS ORDER.*—

(1) *IN GENERAL.*—Section 1862(b)(1) of the Social Security Act (42 U.S.C. 1395y(b)(1)), as amended by subsection (b)(1) of this section, is amended by adding at the end the following new subparagraph:

“(D) *TREATMENT OF CERTAIN MEMBERS OF RELIGIOUS ORDERS.*—In this subsection, an individual shall not be considered to be employed, or an employee, with respect to the performance of services as a member of a religious order which are considered employment only by virtue of an election made by the religious order under section 3121(r) of the Internal Revenue Code of 1986.”

(2) *EFFECTIVE DATE.*—The amendment made by paragraph (1) shall apply to items and services furnished on or after October 1, 1989.

SEC. 6203. PAYMENT FOR END STAGE RENAL DISEASE SERVICES.

(a) *MAINTENANCE OF CURRENT COMPOSITE RATE.*—

(1) *IN GENERAL.*—Section 9335(a)(1) of the Omnibus Budget Reconciliation Act of 1986 is amended—

(A) by striking “and before October 1, 1988” and inserting “and before October 1, 1990”, and

(B) by adding at the end the following: “No change may be made in the base rate in effect as of September 30, 1990, unless the Secretary makes such change in accordance with notice and comment requirements set forth in section 1871(b)(1).”

(2) *EFFECTIVE DATE.*—The amendment made by paragraph (1) shall take effect as if included in the enactment of the Omnibus Budget Reconciliation Act of 1986.

(b) *REQUIREMENTS FOR PATIENTS DEALING DIRECTLY WITH MEDICARE.*—

(1) *LIMITATION ON AMOUNT OF PAYMENT GENERALLY.*—Section 1881(b)(7) of the Social Security Act (42 U.S.C. 1395rr(b)(7)) is amended by inserting after the second sentence the following new sentence: “The amount of a payment made under any method other than a method based on a single composite weighted formula may not exceed the amount (or, in the case of continuous cycling peritoneal dialysis, 130 percent of the amount) of the median payment that would have been made under the formula for hospital-based facilities.”

(2) *AGREEMENTS WITH PROVIDERS OF SERVICES.*—Section 1881(b)(4) of such Act (42 U.S.C. 1395rr(b)(4)) is amended—

(A) by striking “(4)” and inserting “(4)(A)”, and

(B) by adding at the end the following new subparagraph:

“(B) The Secretary shall make payments to a supplier of home dialysis supplies and equipment furnished to a patient whose self-care

home dialysis is not under the direct supervision of an approved provider of services or renal dialysis facility only in accordance with a written agreement under which—

“(i) the patient certifies that the supplier is the sole provider of such supplies and equipment to the patient,

“(ii) the supplier agrees to receive payment for the cost of such supplies and equipment only on an assignment-related basis, and

“(iii) the supplier certifies that it has entered into a written agreement with an approved provider of services or renal dialysis facility under which such provider or facility agrees to furnish to such patient all self-care home dialysis support services and all other necessary dialysis services and supplies, including institutional dialysis services and supplies and emergency services.”

(3) **EFFECTIVE DATE.**—The amendments made by this subsection shall apply with respect to dialysis services, supplies, and equipment furnished on or after February 1, 1990.

SEC. 6204. PHYSICIAN OWNERSHIP OF, AND REFERRAL TO, HEALTH CARE ENTITIES.

(a) **PROHIBITION OF CERTAIN FINANCIAL ARRANGEMENTS BETWEEN REFERRING PHYSICIANS AND CLINICAL LABORATORIES.**—Title XVIII of the Social Security Act is amended by inserting after section 1876 the following new section:

“LIMITATION ON CERTAIN PHYSICIAN REFERRALS

“SEC. 1877. (a) PROHIBITION OF CERTAIN REFERRALS.—

“(1) **IN GENERAL.**—Except as provided in subsection (b), if a physician (or immediate family member of such physician) has a financial relationship with an entity specified in paragraph (2), then—

“(A) the physician may not make a referral to the entity for the furnishing of clinical laboratory services for which payment otherwise may be made under this title, and

“(B) the entity may not present or cause to be presented a claim under this title or bill to any individual, third party payor, or other entity for clinical laboratory services furnished pursuant to a referral prohibited under subparagraph (A).

“(2) **FINANCIAL RELATIONSHIP SPECIFIED.**—For purposes of this section, a financial relationship of a physician (or immediate family member) with an entity specified in this paragraph is—

“(A) except as provided in subsections (c), (d), and (e), an ownership or investment interest in the entity; or

“(B) except as provided in subsection (e), a compensation arrangement (as defined in subsection (h)(1)(A)) between the physician (or immediate family member) and the entity.

An ownership or investment interest described in subparagraph (A) may be through equity, debt, or other means.

“(b) **GENERAL EXCEPTIONS TO BOTH OWNERSHIP AND COMPENSATION ARRANGEMENT PROHIBITIONS.**—Subsection (a)(1) shall not apply in the following cases:

“(1) PHYSICIANS’ SERVICES.—In the case of physicians’ services (as defined in section 1861(q)) provided personally by (or under the personal supervision of) another physician in the same group practice (as defined in subsection (h)(4)) as the referring physician.

“(2) IN-OFFICE ANCILLARY SERVICES.—In the case of services—

“(A) that are furnished—

“(i) personally by the referring physician, personally by a physician who is a member of the same group practice as the referring physician, or personally by individuals who are employed by such physician or group practice and who are personally supervised by the physician or by another physician in the group practice, and

“(ii)(I) in a building in which the referring physician (or another physician who is a member of the same group practice) furnishes physicians’ services unrelated to the furnishing of clinical laboratory services, or

“(II) in the case of a referring physician who is a member of a group practice, in another building which is used by the group practice for the centralized provision of the group’s clinical laboratory services, and

“(B) that are billed by the physician performing or supervising the services, by a group practice of which such physician is a member, or by an entity that is wholly owned by such physician or such group practice,

if the ownership or investment interest in such services meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.

“(3) PREPAID PLANS.—In the case of services furnished—

“(A) by an organization with a contract under section 1876 to an individual enrolled with the organization,

“(B) by an organization described in section 1833(a)(1)(A) to an individual enrolled with the organization, or

“(C) by an organization receiving payments on a prepaid basis, under a demonstration project under section 402(a) of the Social Security Amendments of 1967 or under section 222(a) of the Social Security Amendments of 1972, to an individual enrolled with the organization.

“(5) OTHER PERMISSIBLE EXCEPTIONS.—In the case of any other financial relationship which the Secretary determines, and specifies in regulations, does not pose a risk of program or patient abuse.

“(c) GENERAL EXCEPTION RELATED ONLY TO OWNERSHIP OR INVESTMENT PROHIBITION FOR OWNERSHIP IN PUBLICLY-TRADED SECURITIES.—Ownership of investment securities (including shares or bonds, debentures, notes, or other debt instruments) which were purchased on terms generally available to the public and which are in a corporation that—

“(1) is listed for trading on the New York Stock Exchange or on the American Stock Exchange, or is a national market system security traded under an automated interdealer quotation system operated by the National Association of Securities Dealers, and

"(2) had, at the end of the corporation's most recent fiscal year, total assets exceeding \$100,000,000, shall not be considered to be an ownership or investment interest described in subsection (a)(2)(A).

"(d) **ADDITIONAL EXCEPTIONS RELATED ONLY TO OWNERSHIP OR INVESTMENT PROHIBITION.**—The following, if not otherwise excepted under subsection (b), shall not be considered to be an ownership or investment interest described in subsection (a)(2)(A):

"(1) **HOSPITALS IN PUERTO RICO.**—In the case of clinical laboratory services provided by a hospital located in Puerto Rico.

"(2) **RURAL PROVIDER.**—In the case of clinical laboratory services if the laboratory furnishing the services is in a rural area (as defined in section 1886(d)(2)(D)).

"(3) **HOSPITAL OWNERSHIP.**—In the case of clinical laboratory services provided by a hospital (other than a hospital described in paragraph (1)) if—

"(A) the referring physician is authorized to perform services at the hospital, and

"(B) the ownership or investment interest is in the hospital itself (and not merely in a subdivision thereof).

"(e) **EXCEPTIONS RELATING TO OTHER COMPENSATION ARRANGEMENTS.**—The following shall not be considered to be a compensation arrangement described in subsection (a)(2)(B):

"(1) **RENTAL OF OFFICE SPACE.**—Payments made for the rental or lease of office space if—

"(A) there is a written agreement, signed by the parties, for the rental or lease of the space, which agreement—

"(i) specifies the space covered by the agreement and dedicated for the use of the lessee,

"(ii) provides for a term of rental or lease of at least one year;

"(iii) provides for payment on a periodic basis of an amount that is consistent with fair market value;

"(iv) provides for an amount of aggregate payments that does not vary (directly or indirectly) based on the volume or value of any referrals of business between the parties; and

"(v) would be considered to be commercially reasonable even if no referrals were made between the parties;

"(B) in the case of rental or lease of office space in which a physician who is an interested investor (or an interested investor who is an immediate family member of the physician) has an ownership or investment interest, the office space is in the same building as the building in which the physician (or group practice of which the physician is a member) has a practice; and

"(C) the arrangement meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.

"(2) **EMPLOYMENT AND SERVICE ARRANGEMENTS WITH HOSPITALS.**—An arrangement between a hospital and a physician (or immediate family member) for the employment of the physician (or family member) or for the provision of administrative services, if—

“(A) the arrangement is for identifiable services;

“(B) the amount of the remuneration under the arrangement—

“(i) is consistent with the fair market value of the services, and

“(ii) is not determined in a manner that takes into account (directly or indirectly) the volume or value of any referrals by the referring physician;

“(C) the remuneration is provided pursuant to an agreement which would be commercially reasonable even if no referrals were made to the hospital; and

“(D) the arrangement meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.

“(3) OTHER SERVICE ARRANGEMENTS.—Remuneration from an entity (other than a hospital) under an arrangement if—

“(A) the arrangement is—

“(i) for specific identifiable services as the medical director or as a member of a medical advisory board at the entity pursuant to a requirement of this title,

“(ii) for specific identifiable physicians’ services to be furnished to an individual receiving hospice care if payment for such services may only be made under this title as hospice care,

“(iii) for specific physicians’ services furnished to a nonprofit blood center, or

“(iv) for specific identifiable administrative services (other than direct patient care services), but only under exceptional circumstances specified by the Secretary in regulations;

“(B) the requirements described in subparagraphs (B) and (C) of paragraph (2) are met with respect to the entity in the same manner as they apply to a hospital; and

“(C) the arrangement meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.

“(4) PHYSICIAN RECRUITMENT.—In the case of remuneration which is provided by a hospital to a physician to induce the physician to relocate to the geographic area served by the hospital in order to be a member of the medical staff of the hospital, if—

“(A) the physician is not required to refer patients to the hospital,

“(B) the amount of the remuneration under the arrangement is not determined in a manner that takes into account (directly or indirectly) the volume or value of any referrals by the referring physician, and

“(C) the arrangement meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.

“(5) ISOLATED TRANSACTIONS.—In the case of an isolated financial transaction, such as a one-time sale of property, if—

“(A) the requirements described in subparagraphs (B) and (C) of paragraph (2) are met with respect to the entity in the same manner as they apply to a hospital, and

“(B) the transaction meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.

“(6) **SALARIED PHYSICIANS IN A GROUP PRACTICE.**—A compensation arrangement involving payment by a group practice of the salary of a physician member of the group practice.

“(f) **REPORTING REQUIREMENTS.**—Each entity providing covered items or services for which payment may be made under this title shall provide the Secretary with the information concerning the entity’s ownership arrangements, including—

“(1) the covered items and services provided by the entity, and

“(2) the names and all of the medicare provider numbers of the physicians who are interested investors or who are immediate relatives of interested investors.

Such information shall be provided in such form, manner, and at such times as the the Secretary shall specify. Such information shall first be provided not later than 1 year after the date of the enactment of this section.

“(g) **SANCTIONS.**—

“(1) **DENIAL OF PAYMENT.**—No payment may be made under this title for a clinical laboratory service which is provided in violation of subsection (a)(1).

“(2) **REQUIRING REFUNDS FOR CERTAIN CLAIMS.**—If a person collects any amounts that were billed in violation of subsection (a)(1), the person shall be liable to the individual for, and shall refund on a timely basis to the individual, any amounts so collected.

“(3) **CIVIL MONEY PENALTY AND EXCLUSION FOR IMPROPER CLAIMS.**—Any person that presents or causes to be presented a bill or a claim for a service that such person knows or should know is for a service for which payment may not be made under paragraph (1) or for which a refund has not been made under paragraph (2) shall be subject to a civil money penalty of not more than \$15,000 for each such service. The provisions of section 1128A (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

“(4) **CIVIL MONEY PENALTY AND EXCLUSION FOR CIRCUMVENTION SCHEMES.**—Any physician or other entity that enters into an arrangement or scheme (such as a cross-referral arrangement) which the physician or entity knows or should know has a principal purpose of assuring referrals by the physician to a particular entity which, if the physician directly made referrals to such entity, would be in violation of this section, shall be subject to a civil money penalty of not more than \$100,000 for each such arrangement or scheme. The provisions of section 1128A (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

"(5) FAILURE TO REPORT INFORMATION.—Any person who is required, but fails, to meet a reporting requirement of subsection (f) is subject to a civil money penalty of not more than \$10,000 for each day for which reporting is required to have been made.

"(h) DEFINITIONS.—For purposes of this section:

"(1) COMPENSATION ARRANGEMENT; REMUNERATION.—(A) The term 'compensation arrangement' means any arrangement involving any remuneration between a physician (or immediate family member) and an entity.

"(B) The term 'remuneration' includes any remuneration, directly or indirectly, overtly or covertly, in cash or in kind.

"(2) EMPLOYEE.—An individual is considered to be 'employed by' or an 'employee' of an entity if the individual would be considered to be an employee of the entity under the usual common law rules applicable in determining the employer-employee relationship (as applied for purposes of section 3121(d)(2) of the Internal Revenue Code of 1986).

"(3) FAIR MARKET VALUE.—The term 'fair market value' means the value in arms length transactions, consistent with the general market value, and, with respect to rentals or leases, the value of rental property for general commercial purposes (not taking into account its intended use) and, in the case of a lease of space, not adjusted to reflect the additional value the prospective lessee or lessor would attribute to the proximity or convenience to the lessor where the lessor is a potential source of patient referrals to the lessee.

"(4) GROUP PRACTICE.—The term 'group practice' means a group of two or more physicians legally organized as a partnership, professional corporation, foundation, not-for-profit corporation, faculty practice plan, or similar association—

"(A) in which each physician who is a member of the group provides substantially the full range of services which the physician routinely provides (including medical care, consultation, diagnosis, or treatment) through the joint use of shared office space, facilities, equipment, and personnel;

"(B) for which substantially all of the services of the physicians who are members of the group are provided through the group and are billed in the name of the group and amounts so received are treated as receipts of the group;

"(C) in which the overhead expenses of and the income from the practice are distributed in accordance with methods previously determined by members of the group; and

"(D) which meets such other standards as the Secretary may impose by regulation.

In the case of a faculty practice plan associated with a hospital with an approved medical residency training program in which physician members may provide a variety of different specialty services and provide professional services both within and outside the group (as well as perform other tasks such as research), the previous sentence shall be applied only with respect to the services provided within the faculty practice plan.

"(5) **INTERESTED INVESTOR; DISINTERESTED INVESTOR.**—The term 'interested investor' means, with respect to an entity, an investor who is a physician in a position to make or to influence referrals or business to the entity (or who is an immediate family member of such an investor), and the term 'disinterested investor' means an investor other than an interested investor.

"(6) **REFERRAL; REFERRING PHYSICIAN.**—

"(A) **PHYSICIANS' SERVICES.**—Except as provided in subparagraph (C), in the case of a clinical laboratory service which under law is required to be provided by (or under the supervision of) a physician, the request by a physician for the service, including the request by a physician for a consultation with another physician (and any test or procedure ordered by, or to be performed by (or under the supervision of) that other physician), constitutes a 'referral' by a 'referring physician'.

"(B) **OTHER ITEMS.**—Except as provided in subparagraph (C), in the case of another clinical laboratory service, the request or establishment of a plan of care by a physician which includes the provision of the clinical laboratory service constitutes a 'referral' by a 'referring physician'.

"(C) **CLARIFICATION RESPECTING CERTAIN SERVICES INTEGRAL TO A CONSULTATION BY CERTAIN SPECIALISTS.**—A request by a pathologist for clinical diagnostic laboratory tests and pathological examination services, if such services are furnished by (or under the supervision of) such pathologist pursuant to a consultation requested by another physician does not constitute a 'referral' by a 'referring physician'."

(b) **REQUIRING REQUESTS FOR PAYMENT TO INCLUDE INFORMATION ON REFERRING PHYSICIAN.**—Section 1833 of such Act (42 U.S.C. 1395l) is amended by adding at the end the following new subsection:

"(q)(1) Each request for payment, or bill submitted, for an item or service furnished by an entity for which payment may be made under this part and for which the entity knows or has reason to believe there has been a referral by a referring physician (within the meaning of section 1877) shall include the name and provider number for the referring physician and indicate whether or not the referring physician is an interested investor (within the meaning of section 1877(h)(5)).

"(2)(A) In the case of a request for payment for an item or service furnished by an entity under this part on an assignment-related basis and for which information is required to be provided under paragraph (1) but not included, payment may be denied under this part.

"(B) In the case of a request for payment for an item or service furnished by an entity under this part not submitted on an assignment-related basis and for which information is required to be provided under paragraph (1) but not included—

"(i) if the entity knowingly and willfully fails to provide such information promptly upon request of the Secretary or a carrier, the entity may be subject to a civil money penalty in an amount not to exceed \$2,000, and

“(ii) if the entity knowingly, willfully, and in repeated cases fails, after being notified by the Secretary of the obligations and requirements of this subsection to provide the information required under paragraph (1), the entity may be subject to exclusion from participation in the programs under this Act for a period not to exceed 5 years, in accordance with the procedures of subsections (c), (f), and (g) of section 1128.

The provisions of section 1128A (other than subsections (a) and (b)) shall apply to civil money penalties under clause (i) in the same manner as they apply to a penalty or proceeding under section 1128A(a).”.

(c) **EFFECTIVE DATES.**—

(1) Except as provided in paragraph (2), the amendments made by this section shall become effective with respect to referrals made on or after January 1, 1992.

(2) The reporting requirement of section 1877(f) of the Social Security Act shall take effect on October 1, 1990.

(d) **DEADLINE FOR CERTAIN REGULATIONS.**—The Secretary of Health and Human Services shall publish final regulations to carry out section 1877 of the Social Security Act by not later than October 1, 1990.

(e) **GAO STUDY OF OWNERSHIP BY REFERRING PHYSICIANS.**—The Comptroller General shall conduct a study of the ownership of hospitals and other providers of medicare services by referring physicians. Such study shall investigate—

(1) the types of such ownership arrangements and types of services offered under such arrangements,

(2) the returns generally earned by physician investors in such arrangements,

(3) the effect of such arrangements on (A) the utilization of items and services by medicare beneficiaries, (B) medicare expenditures, and (C) other entities providing items and services in the communities served,

(4) the effect of such arrangements on independent providers of similar services, and

(5) the effect on the provision of in-office clinical laboratory services of the limitation on payment for certain referrals contained in section 1877 of the Social Security Act.

By not later than February 1, 1991, the Comptroller General shall report to Congress on the results of such study.

(f) **QUARTERLY REPORTS TO CONGRESS ON COMPARATIVE UTILIZATION.**—The Secretary of Health and Human Services shall submit to the Congress and the Comptroller General, not later than 90 days after the end of each calendar quarter, a report which provides a statistical profile (by State and type of item or service) comparing utilization of items and services by medicare beneficiaries served by entities in which the referring physician has a direct or indirect financial interest and by medicare beneficiaries served by other entities.

SEC. 6205. COSTS OF NURSING AND ALLIED HEALTH EDUCATION.

(a) **RECOGNITION OF COSTS OF CERTAIN HOSPITAL-BASED NURSING SCHOOLS.**—

(1) *IN GENERAL.*—(A) The reasonable costs incurred by a hospital in training students of a hospital-based nursing school shall be allowable as reasonable costs under title XVIII of the Social Security Act and reimbursed under such title on the same basis as if they were allowable direct costs of a hospital-operated educational program (other than an approved graduate medical education program) if, before June 15, 1989, and thereafter, the hospital demonstrates that for each year, it incurs at least 50 percent of the costs of training nursing students at such school, the nursing school and the hospital share some common board members, and all instruction is provided at the hospital or, if in another building, a building on the immediate grounds of the hospital.

(B) Section 8411(b) of the Technical and Miscellaneous Revenue Act of 1988 is amended by striking “1989, 1990, and” and inserting “1986 through”.

(2) *EFFECTIVE DATE.*—Paragraph (1)(A) shall apply with respect to cost reporting periods beginning on or after the date of the enactment of this Act and on or before the date on which the Secretary issues regulations pursuant to subsection (b)(2)(A)..

(b) *DELAY IN RECOUPMENT OF CERTAIN NURSING AND ALLIED EDUCATION COSTS.*—

(1) The Secretary of Health and Human Services (in this subsection referred to as the “Secretary”) shall not, before October 1, 1990, recoup from, or otherwise reduce or adjust payments under title XVIII of the Social Security Act to, hospitals because of alleged overpayments to such hospitals under such title due to a determination that costs which were reported by a hospital on its Medicare cost reports relating to approved nursing and allied health education programs were allowable costs and are included in the definition of “operating costs of inpatient hospital services” pursuant to section 1886(a)(4) of such Act, so that no pass-through of such costs were permitted under that section.

(2)(A) Before July 1, 1990, the Secretary shall issue regulations respecting payment of costs described in paragraph (1).

(B) In issuing such regulations—

(i) the Secretary shall allow a comment period of not less than 60 days,

(ii) the Secretary shall consult with the Prospective Payment Assessment Commission, and

(iii) any final rule shall not be effective prior to October 1, 1990, or 30 days after publication of the final rule in the Federal Register, whichever is later.

(C) Such regulations shall specify—

(i) the relationship required between an approved nursing or allied health education program and a hospital for the program’s costs to be attributed to the hospital;

(ii) the types of costs related to nursing or allied health education programs that are allowable by Medicare;

(iii) the distinction between costs of approved educational activities as recognized under section 1886(a)(3) of the Social Security Act and educational costs treated as operating costs of inpatient hospital services; and

(iv) the treatment of other funding sources for the program.

SEC. 6206. DISCLOSURE OF ASSUMPTIONS IN ESTABLISHING AAPCC; ELIMINATION OF COORDINATED OPEN ENROLLMENT REQUIREMENT.

(a) DISCLOSURE OF ASSUMPTIONS IN ESTABLISHING AAPCC.—

(1) *IN GENERAL.*—Section 1876(a)(1) of the Social Security Act (42 U.S.C. 1395mm(a)(1)) is amended by adding at the end the following new subparagraph:

“(F)(i) At least 45 days before making the announcement under subparagraph (A) for a year (beginning with the announcement for 1991), the Secretary shall provide for notice to eligible organizations of proposed changes to be made in the methodology or benefit coverage assumptions from the methodology and assumptions used in the previous announcement and shall provide such organizations an opportunity to comment on such proposed changes.

“(ii) In each announcement made under subparagraph (A) for a year (beginning with the announcement for 1991), the Secretary shall include an explanation of the assumptions (including any benefit coverage assumptions) and changes in methodology used in the announcement in sufficient detail so that eligible organizations can compute per capita rates of payment for classes of individuals located in each county (or equivalent area) which is in whole or in part within the service area of such an organization.”

(2) Before July 1, 1990, the Secretary of Health and Human Services shall provide for notice to eligible organizations of the methodology used in making the announcement under section 1876(a)(1)(A) of the Social Security Act for 1990.

(b) ELIMINATION OF COORDINATED OPEN ENROLLMENT REQUIREMENT.—

(1) *IN GENERAL.*—Section 1876(c)(3)(A) of such Act (42 U.S.C. 1395mm(c)(3)(A)) is amended—

(A) in clause (i), by striking “30-day period” and inserting “period or periods”, and

(B) by striking clause (ii) and inserting the following:

“(ii)(I) If a risk-sharing contract under this section is not renewed or is otherwise terminated, eligible organizations with risk-sharing contracts under this section and serving a part of the same service area as under the terminated contract are required to have an open enrollment period for individuals who were enrolled under the terminated contract as of the date of notice of such termination. If a risk-sharing contract under this section is renewed in a manner that discontinues coverage for individuals residing in part of the service area, eligible organizations with risk-sharing contracts under this section and enrolling individuals residing in that part of the service area are required to have an open enrollment period for individuals residing in the part of the service area who were enrolled under the contract as of the date of notice of such discontinued coverage.

“(II) The open enrollment periods required under subclause (I) shall be for 30 days and shall begin 30 days after the date that the Secretary provides notice of such requirement.

“(III) Enrollment under this clause shall be effective 30 days after the end of the open enrollment period, or, if the Secretary deter-

mines that such date is not feasible, such other date as the Secretary specifies.”

(2) **EFFECTIVE DATE.**—The amendments made by paragraph (1) shall take effect 60 days after the date of the enactment of this Act.

SEC. 6207. EXTENSION OF EXPIRING AUTHORITIES.

(a) **DELAY IN EFFECTIVE DATE IN PHYSICIAN INCENTIVE RULES.**—Section 9313(c)(2)(B) of the Omnibus Budget Reconciliation Act of 1986, as amended by section 4016 of the Omnibus Budget Reconciliation Act of 1987, is amended by striking “April 1, 1990” and inserting “April 1, 1991”.

(b) **EXTENSION OF PROHIBITION ON COST SAVINGS POLICIES BEFORE BEGINNING OF FISCAL YEAR.**—Section 4039(d) of the Omnibus Budget Reconciliation Act of 1987, as amended by section 426(e) of the Medicare Catastrophic Coverage Act of 1988, is amended—

(1) by striking “October 15, 1989” and inserting “October 15, 1990”, and

(2) by inserting “or in fiscal year 1991” after “fiscal year 1990”.

Subpart B—Technical and Miscellaneous Provisions

SEC. 6211. MEDICARE HOSPITAL PATIENT PROTECTION AMENDMENTS.

(a) **SCOPE OF HOSPITAL RESPONSIBILITY FOR SCREENING.**—Subsection (a) of section 1867 of the Social Security Act (42 U.S.C. 1395dd) is amended by striking “department” the third place it appears and inserting the following: “department, including ancillary services routinely available to the emergency department,”.

(b) **INFORMED REFUSALS OF TREATMENT OR TRANSFERS.**—Subsection (b) of such section is amended—

(1) in paragraph (2)—

(A) by inserting “and informs the individual (or a person acting on the individual’s behalf) of the risks and benefits to the individual of such examination and treatment,” after “in that paragraph”,

(B) by striking “or treatment” and inserting “and treatment”, and

(C) by adding at the end the following new sentence: “The hospital shall take all reasonable steps to secure the individual’s (or person’s) written informed consent to refuse such examination and treatment.”; and

(2) in paragraph (3)—

(A) by inserting “and informs the individual (or a person acting on the individual’s behalf) of the risks and benefits to the individual of such transfer,” after “with subsection (c)”, and

(B) by adding at the end the following new sentence: “The hospital shall take all reasonable steps to secure the individual’s (or person’s) written informed consent to refuse such transfer.”.

(c) **AUTHORIZATION FOR TRANSFERS.**—

(1) **INFORMED CONSENT FOR TRANSFERS AT INDIVIDUAL REQUEST.**—Subsection (c)(1)(A)(i) of such section is amended by

striking “requests that the transfer be effected” and inserting “after being informed of the hospital’s obligations under this section and of the risk of transfer, in writing requests transfer to another medical facility”.

(2) **CLARIFYING PHYSICIAN AUTHORIZATION FOR TRANSFERS.**—Subsection (c)(1)(A) of such section is amended—

(A) by striking “or” at the end of clause (i);

(B) in clause (ii)—

(i) by striking “, or other qualified medical personnel when a physician is not readily available in the emergency department,”; and

(ii) by inserting “of transfer” after “information available at the time”;

(C) by striking “; and” at the end of clause (ii) and inserting “, or”; and

(D) by adding at the end the following new clause:

“(iii) if a physician is not physically present in the emergency department at the time an individual is transferred, a qualified medical person (as defined by the Secretary in regulations) has signed a certification described in clause (ii) after a physician (as defined in section 1861(r)(1)), in consultation with the person, has made the determination described in such clause, and subsequently countersigns the certification; and”.

(3) **STANDARD FOR AUTHORIZING TRANSFER.**—Subsection (c)(1)(A)(ii) of such section is amended—

(A) by striking “, based upon the reasonable risks and benefits to the patient, and”, and

(B) by striking “individual’s medical condition” and inserting “individual and, in the case of labor, to the unborn child”.

(4) **INCLUSION OF SUMMARY OF RISKS AND BENEFITS IN CERTIFICATE OF TRANSFER.**—Subsection (c)(1) of such section is amended by adding at the end the following: “A certification described in clause (ii) or (iii) of subparagraph (A) shall include a summary of the risks and benefits upon which the certification is based.”.

(5) **PROVISION OF SERVICES PENDING TRANSFER.**—Subsection (c)(2) of such section is amended—

(A) by redesignating subparagraphs (A) through (D) as subparagraphs (B) through (E), respectively, and

(B) by inserting before subparagraph (B), as so redesignated, the following new subparagraph:

“(A) in which the transferring hospital provides the medical treatment within its capacity which minimizes the risks to the individual’s health and, in the case of a woman in labor, the health of the unborn child;”.

(d) **REQUIRING MAINTENANCE OF RECORDS OF TRANSFERS.**—Subsection (c)(2)(C) of such section, as redesignated by subsection (c)(5)(A) of this section, is amended—

(1) by striking “provides” and inserting “sends to”, and

(2) by striking “with appropriate medical records” and all that follows through “transferring hospital” and inserting “all medical records (or copies thereof), related to the emergency con-

dition for which the individual has presented, available at the time of the transfer, including records related to the individual's emergency medical condition, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests and the informed written consent or certification (or copy thereof) provided under paragraph (1)(A), and the name and address of any on-call physician (described in subsection (d)(2)(C)) who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment”.

(e) **PHYSICIAN LIABILITY.**—Subsection (d)(2) of such subsection is amended—

(1) by amending subparagraph (B) to read as follows:

“(B) Subject to subparagraph (C), any physician who is responsible for the examination, treatment, or transfer of an individual in a participating hospital, including a physician on-call for the care of such an individual, and who knowingly violates a requirement of this section, including a physician who—

“(i) signs a certification under subsection (c)(1)(A) that the medical benefits reasonably to be expected from a transfer to another facility outweigh the risks associated with the transfer, if the physician knew or should have known that the benefits did not outweigh the risks, or

“(ii) misrepresents an individual's condition or other information, including a hospital's obligations under this section,

is subject to a civil money penalty of not more than \$50,000 for each such violation and, if the violation is knowing and willful or negligent, to exclusion from participation in this title and State health care programs. The provisions of section 1128A (other than the first and second sentences of subsection (a) and subsection (b)) shall apply to a civil money penalty and exclusion under this subparagraph in the same manner as such provisions apply with respect to a penalty, exclusion, or proceeding under section 1128A(a).”; and

(2) by striking subparagraph (C) and inserting the following:

“(C) If, after an initial examination, a physician determines that the individual requires the services of a physician listed by the hospital on its list of on-call physicians (required to be maintained under section 1866(a)(1)(I)) and notifies the on-call physician and the on-call physician fails or refuses to appear within a reasonable period of time, and the physician orders the transfer of the individual because the physician determines that without the services of the on-call physician the benefits of transfer outweigh the risks of transfer, the physician authorizing the transfer shall not be subject to a penalty under subparagraph (B). However, the previous sentence shall not apply to the hospital or to the on-call physician who failed or refused to appear.”.

(f) **ADDITIONAL OBLIGATIONS.**—Such section is amended by adding at the end the following new subsections:

“(g) **NONDISCRIMINATION.**—A participating hospital that has specialized capabilities or facilities (such as burn units, shock-trauma units, neonatal intensive care units, or (with respect to rural areas)

regional referral centers as identified by the Secretary in regulation) shall not refuse to accept an appropriate transfer of an individual who requires such specialized capabilities or facilities if the hospital has the capacity to treat the individual.

“(h) *NO DELAY IN EXAMINATION OR TREATMENT.*—A participating hospital may not delay provision of an appropriate medical screening examination required under subsection (a) or further medical examination and treatment required under subsection (b) in order to inquire about the individual’s method of payment or insurance status.

“(i) *WHISTLEBLOWER PROTECTIONS.*—A participating hospital may not penalize or take adverse action against a physician because the physician refuses to authorize the transfer of an individual with an emergency medical condition that has not been stabilized.”.

(g) *CHANGE IN “PATIENT” TERMINOLOGY.*—

(1) Subsection (c) of such section is amended—

(A) by striking “PATIENT” and inserting “INDIVIDUAL”, and

(B) by striking “a patient” “the patient”, “patient’s”, and “patients” each place each appears and inserting “an individual”, “the individual”, “individual’s”, and “individuals”, respectively.

(2) Subsection (e)(5) of such section is amended by striking “a patient” each place it appears and inserting “an individual”.

(h) *CLARIFICATION OF “EMERGENCY MEDICAL CONDITION” DEFINITION.*—

(1) *IN GENERAL.*—Subsection (e) of such section (as amended by section 6003(g)(3)(D)(xiv)) is amended—

(A) in paragraph (1), by striking “means” and all that follows and inserting the following:

“means—

“(A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—

“(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

“(ii) serious impairment to bodily functions, or

“(iii) serious dysfunction of any bodily organ or part;

or

“(B) with respect to a pregnant woman who is having contractions—

“(i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or

“(ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.”;

(B) by striking paragraph (2);

(C) in paragraph (4)(A)—

(i) by inserting “described in paragraph (1)(A)” after “emergency medical condition”,

(ii) by inserting “or occur during” after “likely to result from”,

(iii) by inserting before the period at the end the following: “, or, with respect to an emergency medical condition described in paragraph (1)(B), to deliver (including the placenta)”;

(D) in paragraph (4)(B)—

(i) by inserting “described in paragraph (1)(A)” after “emergency medical condition”,

(ii) by inserting “or occur during” after “to result from”, and

(iii) by inserting before the period at the end the following: “, or, with respect to an emergency medical condition described in paragraph (1)(B), that the woman has delivered (including the placenta)”;

(E) by redesignating paragraphs (3) through (6) as paragraphs (2) through (5), respectively.

(2) **CONFORMING AMENDMENTS.**—Such section is further amended—

(A) in the heading, by striking “ACTIVE”;

(B) in subsection (a), by striking “or to determine if the individual is in active labor (within the meaning of section (e)(2))”;

(C) in the heading of subsection (b), by striking “ACTIVE”;

(D) in subsection (b)(1)—

(i) by striking “or is in active labor”, and

(ii) in subparagraph (A), by striking “or to provide for treatment of the labor”; and

(E) in subsection (c)(1), by striking “(e)(4)(B)) or is in active labor” and inserting “(e)(3)(B))”.

(i) **EFFECTIVE DATE.**—The amendments made by this section shall take effect on the first day of the first month that begins more than 180 days after the date of the enactment of this Act, without regard to whether regulations to carry out such amendments have been promulgated by such date.

SEC. 6212. HEALTH MAINTENANCE ORGANIZATIONS AND COMPETITIVE MEDICAL PLANS.

(a) **TEMPORARY WAIVER FOR WATTS HEALTH FOUNDATION.**—Section 9312(c)(3)(D) of the Omnibus Budget Reconciliation Act of 1986, as added by section 4018(d) of the Omnibus Budget Reconciliation Act of 1987, is amended—

(1) in clause (i), by striking “January 1, 1990” and inserting “January 1, 1994”; and

(2) by amending clauses (ii) and (iii) to read as follows:

“(ii) beginning on January 1, 1990, the Secretary of Health and Human Service shall conduct an annual review of the organization to determine the organization’s compliance with the quality assurance requirements of section 1876(c)(6) of such Act; and

“(iii) after January 1, 1990, if the organization receives an unfavorable review under clause (ii), the Secretary, after notice to the organization of the unfavorable review and an opportunity to correct any deficiencies identified during the review, may provide for the sanction described in section 1876(f)(3) of such Act ef-

fective with respect to individuals enrolling with the organization after the date the Secretary notifies the organization that the organization is not in compliance with the requirements of section 1876(c)(6) of such Act.”.

(b) LIMIT ON CHARGES FOR EMERGENCY SERVICES AND OUT-OF-AREA COVERAGE.—

(1) IN GENERAL.—Section 1876 of the Social Security Act (42 U.S.C. 1395mm) is amended by adding at the end the following new subsection:

“(j)(1)(A) In the case of physicians’ services described in paragraph (2) which are furnished by a participating physician to an individual enrolled with an eligible organization under this section and enrolled under part B, the participation agreement under section 1842(h)(1) is deemed to provide that the physician will accept as payment in full from the eligible organization the amount that would be payable to the physician under part B and from the individual under such part, if the individual were not enrolled with an eligible organization under this section.

“(B) In the case of physicians’ services described in paragraph (2) which are furnished by a nonparticipating physician, the limitations on actual charges for such services otherwise applicable under part B (to services furnished by individuals not enrolled with an eligible organization under this section) shall apply in the same manner as such limitations apply to services furnished to individuals not enrolled with such an organization.

“(2) The physicians’ services described in this paragraph are physicians’ services which—

“(A) are emergency services or out-of-area coverage (described in clauses (iii) and (iv) of subsection (b)(2)(A)), and

“(B) are furnished to an enrollee of an eligible organization under this section by a person who is not under a contract with the organization.”.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to services furnished on or after April 1, 1990.

(c) MAKING AUTHORITY FOR BENEFIT STABILIZATION FUND PERMANENT.—

(1) REPEAL ON LIMITATION ON ESTABLISHMENT OF A FUND.—Section 2350(b) of the Deficit Reduction Act of 1984 (Public Law 98-369) is amended by striking paragraphs (3) and (4).

(2) REPEAL ON LIMITING PERIOD OF USE.—Section 1876(g)(5) of the Social Security Act (42 U.S.C. 1395mm(g)(5)) is amended by striking “and during a period of not longer than four years”.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall take effect on the date of the enactment of this Act.

SEC. 6213. RURAL HEALTH CLINIC SERVICES.

(a) STAFFING REQUIREMENTS; INCLUSION OF NURSE-MIDWIFE SERVICES.—Section 1861(aa)(2) of the Social Security Act (42 U.S.C. 1395x(aa)(2)) is amended—

(1) by striking “; and” at the end of subparagraph (I) and inserting a semicolon;

(2) by redesignating subparagraph (J) as subparagraph (K); and

(3) by inserting after subparagraph (I) the following new subparagraph:

“(J) has a nurse practitioner, a physician assistant, or a certified nurse-midwife (as defined in subsection (gg)) available to furnish patient care services not less than 50 percent of the time the clinic operates; and”.

(b) **COVERAGE OF SOCIAL WORKER SERVICES.**—Section 1861(aa)(1)(B) of such Act (42 U.S.C. 1395x(aa)(1)(B)) is amended—

(1) by striking “or” before “by”; and

(2) by inserting “or by a clinical social worker (as defined in subsection (hh)(1)),” after “Secretary”.

(c) **EXPANSION OF ELIGIBLE AREAS.**—The second sentence of section 1861(aa)(2) of such Act is amended—

(1) by striking “designated by the Secretary” and inserting “designated by the chief executive officer of the State and certified by the Secretary as an area with a shortage of personal health services, or that is designated by the Secretary”;

(2) by striking “section 1302(7) of the Public Health Service Act or” and inserting “sections 330(b)(3) or 1302(7) of the Public Health Service Act,”; and

(3) by striking “medical care manpower,” and inserting the following: “medical care manpower, (III) as a high impact area described in section 329(a)(5) of that Act, or (IV) as an area which includes a population group which the Secretary determines has a health manpower shortage under section 332(a)(1)(B) of that Act,”.

(d) **EFFECTIVE DATE.**—The amendments made by subsections (a) through (c) of this section shall take effect October 1, 1989.

(e) **DISSEMINATION OF RURAL HEALTH CLINIC INFORMATION.**—

(1) **IN GENERAL.**—Not later than 60 days after the date of the enactment of this Act, the Secretary of Health and Human Services, in consultation with the Director of the Office of Rural Health Policy, shall disseminate to health care facilities and to the chief executive officer, chief health officer, and chief human services officer of each State, applications and other necessary information to enable such a facility to apply for designation as a rural health clinic for the purposes of titles XVIII and XIX of the Social Security Act.

(2) **DEFINITIONS.**—For purposes of this subsection:

(A) The term “health care facility” means a community health center or a migrant health center, or a hospital, home health agency, or skilled nursing facility participating in a program established under title XVIII or title XIX of the Social Security Act.

(B) The term “State” includes the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa.

(f) **TREATMENT OF CERTAIN FACILITIES AS RURAL HEALTH CLINICS.**—The Secretary of Health and Human Services shall not deny certification of a facility as a rural health clinic under section 1861(aa)(2) of the Social Security Act if the facility is located on an island and would otherwise be qualified to be certified as such a facility but for the requirement that the services of a physician assistant or nurse practitioner be provided in the facility.

(g) **EXPANSION OF FUNCTIONS OF OFFICE OF RURAL HEALTH POLICY.**—Section 711(b) of the Social Security Act (42 U.S.C. 912(b)) is amended—

(1) in paragraph (2)(A), by striking “health care issues” and inserting “health care issues, including rural mental health, rural infant mortality prevention, and rural occupational safety and preventive health promotion”;

(2) in paragraph (2)(C), by striking “rural areas” and inserting “rural areas, including programs providing community-based mental health services, pre-natal and infant care services, and rural occupational safety and preventive health education and promotion”; and

(3) in paragraph (4), by striking “rural health care” and inserting “rural health care, including activities relating to rural mental health, rural infant mortality, and rural occupational safety and preventive health promotion”.

SEC. 6214. DETERMINING ELIGIBILITY OF HOME HEALTH AGENCIES FOR WAIVER OF LIABILITY FOR DENIED CLAIMS.

(a) **SCOPE OF WAIVER AND DETERMINATION OF DENIED CLAIM.**—Section 1879(f) of the Social Security Act (42 U.S.C. 1395pp(f)) is amended—

(1) in paragraph (1), by striking “with respect to” and all that follows and inserting a period; and

(2) in paragraph (4), by striking “(4) The requirement” and inserting “(4)(A) The requirement”, and by adding at the end the following new subparagraph:

“(B) For purposes of determining the rate of denial of bills for a home health agency under subparagraph (A), a bill shall not be considered to be denied until the expiration of the 60-day period that begins on the date such bill is denied by the fiscal intermediary, or, with respect to such a denial for which the agency requests reconsideration, until the fiscal intermediary issues a decision denying payment for such bill.”.

(b) **MONITORING OF DENIED CLAIMS.**—Section 1879(f) of such Act (42 U.S.C. 1395pp(f)) is amended by adding at the end the following new paragraph:

“(6) The Secretary shall monitor the proportion of denied bills submitted by home health agencies for which reconsideration is requested, and shall notify Congress if the proportion of denials reversed upon reconsideration increases significantly.”.

(c) **EFFECTIVE DATE.**—The amendments made by subsection (a) shall apply to determinations for quarters beginning on or after the date of the enactment of this Act.

SEC. 6215. EXTENSION OF AUTHORITY TO CONTRACT WITH FISCAL INTERMEDIARIES AND CARRIERS ON OTHER THAN A COST BASIS.

(a) **IN GENERAL.**—Section 2326(a) of the Deficit Reduction Act of 1984 is amended—

(1) in the first sentence, by striking “fiscal year 1989” and inserting “fiscal year 1993”;

(2) in the second sentence, by striking “over a period of time” and inserting “over a 2-year period of time”, and

(3) by inserting after the second sentence, the following: “In addition, during such period the Secretary may enter into such

additional agreements and contracts without regard to such cost reimbursement provisions if the fiscal intermediary or carrier involved and the Secretary agree to waive such provisions, but the Secretary may not take any action that has the effect of requiring that the intermediary or carrier agree to waive such provisions, including requiring such a waiver as a condition for entering into or renewing such an agreement or contract.”

(b) **EFFECTIVE DATE.**—The amendments made by subsection (a) shall apply beginning with fiscal year 1990.

SEC. 6216. EXPANSION OF RURAL HEALTH MEDICAL EDUCATION DEMONSTRATION PROJECT.

(a) **NUMBER OF PROJECTS.**—Section 4038(a) of the Omnibus Budget Reconciliation Act of 1987 is amended by striking “four sponsoring hospitals” and inserting “10 sponsoring hospitals”.

(b) **SELECTION OF NEW PROJECTS.**—Section 4038(c) of such Act is amended—

(1) by striking “In selecting” and inserting “(1) In selecting”;

(2) by redesignating paragraphs (1) and (2) as subparagraphs (A) and (B); and

(3) by adding at the end the following new paragraph:

“(2) The provisions of paragraph (1) shall not apply with respect to applications submitted as a result of amendments made by section 355 of the Medicare Catastrophic Coverage Repeal Act of 1989.”

(c) **COMMENCEMENT OF NEW PROJECTS.**—Section 4038(e) of such Act is amended by inserting “(or the date of the enactment of the Medicare Catastrophic Coverage Repeal Act of 1989, in the case of a project conducted as a result of the amendments made by section 355 of such Act)” after “this Act”.

SEC. 6217. INNER-CITY HOSPITAL TRIAGE DEMONSTRATION PROJECT.

(a) **ESTABLISHMENT.**—The Secretary of Health and Human Services shall establish a demonstration project in a public hospital that is located in a large urban area and that has established a triage system, under which the Secretary shall make payments for 3 years to reimburse the hospital for the reasonable costs of operating the system, including costs—

(1) to train hospital personnel to operate and participate in the system; and

(2) to provide services to patients who might otherwise be denied appropriate and prompt care.

(b) **LIMITATIONS ON PAYMENT.**—(1) The Secretary may not make payment under the demonstration project established under subsection (a) for costs that the Secretary determines are not reasonable.

(2) The amount of payment made under the demonstration project during a single year may not exceed \$500,000.

SEC. 6218. GAO STUDY OF ADMINISTRATIVE COSTS OF MEDICARE PROGRAM.

(a) **STUDY.**—The Comptroller General shall conduct a study of the administrative burden of medicare regulations and program requirements on providers of services, fiscal intermediaries, and carriers, and shall include in such study—

(1) an assessment of current administrative costs to such entities and of trends in such administrative costs since 1982; and

(2) a comparison of the administrative burden to such entities in providing services to individuals who are not medicare beneficiaries.

For purposes of such assessment, administrative costs shall include personnel costs, training costs, the costs of data and communications systems as affected by changes in requirements of the medicare program, and costs to such entities of non-compliance with such requirements resulting from the failure of the Secretary of Health and Human Services to provide entities with adequate notice of changes in program requirements.

(b) *REPORT*.—Not later than March 31, 1990, the Comptroller General shall submit a report to the Committees on Ways and Means and Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate on the study conducted under subsection (a).

SEC. 6219. PROVISIONS RELATING TO END STAGE RENAL DISEASE SERVICES.

(a) *FLEXIBILITY IN FUNDING ESRD NETWORK ORGANIZATIONS*.—The last sentence of section 1881(b)(7) of the Social Security Act (42 U.S.C. 1395rr(b)(7)) is amended by striking “network administrative” and all that follows and inserting the following: “organizations (designated under subsection (c)(1)(A)) for such organizations’ necessary and proper administrative costs incurred in carrying out the responsibilities described in subsection (c)(2). The Secretary shall provide that amounts paid under this paragraph shall be distributed to the organizations described in subsection (c)(1)(A) to ensure equitable treatment of all such network organizations. The Secretary in distributing any such payments to network organizations shall take into account—

“(A) the geographic size of the network area;

“(B) the number of providers of end stage renal disease services in the network area;

“(C) the number of individuals who are entitled to end stage renal disease services in the network area; and

“(D) the proportion of the aggregate administrative funds collected in the network area.”.

(b) *LIABILITY PROTECTION FOR ESRD NETWORK ORGANIZATIONS AND PROHIBITION AGAINST DISCLOSURE OF INFORMATION*.—Section 1881(c) of such Act (42 U.S.C. 1395rr(c)) is amended by adding at the end the following new paragraph:

“(8) The provisions of sections 1157 and 1160 shall apply with respect to network administrative organizations (including such organizations as medical review boards) with which the Secretary has entered into agreements under this subsection.”.

(c) *REPORT ON PAYMENT FOR ERYTHROPOIETIN (EPO)*.—Not later than April 1, 1990, the Secretary of Health and Human Services shall submit a report to the Committees on Ways and Means and Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate and to the Comptroller General on the methodology and rationale used to establish a payment rate for the drug erythropoietin (EPO) under title XVIII of the Social Security Act and shall include in the report (A) a summary of information provided to the Secretary by the manufacturer of EPO and used

by the Secretary to establish such rate and (B) a plan for ensuring the appropriateness of rates in the future.

SEC. 6220. AMENDMENTS RELATING TO THE UNITED STATES BIPARTISAN COMMISSION ON COMPREHENSIVE HEALTH CARE.

(a) **COMMISSION NAME.**—Section 401 of the Medicare Catastrophic Coverage Act of 1988 is amended by inserting before the period at the end the following: “and also to be known as the ‘Claude Pepper Commission’ or the ‘Pepper Commission’”.

(b) **4 VICE CHAIRMEN.**—Section 403(b) of such Act is amended—

(1) by striking “VICE CHAIRMAN” and inserting “VICE CHAIRMEN”; and

(2) by striking “vice chairman” and inserting “4 vice chairmen”.

(c) **ADDITIONAL MAILING PRIVILEGE.**—Section 405(f) of such Act is amended by inserting before the period at the end the following: “, and shall, for purposes of the frank, be considered a commission of Congress as described in section 3215 of title 39, United States Code”.

(d) **PRINTING OF REPORTS.**—Section 405 of such Act is further amended by adding at the end the following new subsection:

“(j) **PRINTING.**—For purposes of costs relating to printing and binding, including the costs of personnel detailed from the Government Printing Office, the Commission shall be deemed to be a committee of the Congress.”.

(e) **REPORT DEADLINES.**—Section 406 of such Act is amended—

(1) in each of subsections (a) and (b), by striking “, not later than” and all that follows through “for the Commission,”; and

(2) by adding at the end the following new subsection:

“(c) **DEADLINES.**—The two reports required under this section shall be submitted concurrently by not later than November 9, 1989.”.

SEC. 6221. NATIONAL COMMISSION ON CHILDREN.

Section 1139 of the Social Security Act (42 U.S.C. 1320b-9) is amended—

(1) in subsection (d)—

(A) by striking “September 30, 1988” and inserting “March 31, 1990”; and

(B) by striking “March 31, 1989” and inserting “March 31, 1991”;

(2) in subsection (e), by striking “March 31, 1989” and inserting “March 31, 1991”;

(3) in subsection (j), by striking “such sums” and inserting “through fiscal year 1991, such sums”; and

(4) by adding at the end thereof the following new subsections:

“(k)(1) The Commission is authorized to accept donations of money, property, or personal services. Funds received from donations shall be deposited in the Treasury in a separate fund created for this purpose. Funds appropriated for the Commission and donated funds may be expended for such purposes as official reception and representation expenses, public surveys, public service announcements, preparation of special papers, analyses, and documentaries, and for such other purposes as determined by the Commission to be

in furtherance of its mission to review national issues affecting children.

"(2) For purposes of Federal income, estate, and gift taxation, money and other property accepted under paragraph (1) of this subsection shall be considered as a gift or bequest to or for the use of the United States.

"(3) Expenditure of appropriated and donated funds shall be subject to such rules and regulations as may be adopted by the Commission and shall not be subject to Federal procurement requirements.

"(4) The Commission is authorized to conduct such public surveys as it deems necessary in support of its review of national issues affecting children and, in conducting such surveys, the Commission shall not be deemed to be an "agency" for the purpose of 44 U.S.C. 3502."

SEC. 6222. CONTINUED USE OF HOME HEALTH WAGE INDEX IN EFFECT PRIOR TO JULY 1, 1989, UNTIL AFTER JULY 1, 1991.

Notwithstanding the requirement of section 1861(v)(1)(L)(iii) of the Social Security Act, the Secretary of Health and Human Services shall in determining the limits of or reasonable costs under title XVIII of the Social Security Act with respect to services furnished by home health agencies, continue to utilize the wage index that was in effect for cost reporting periods beginning before July 1, 1989, until cost reporting periods beginning on or after July 1, 1991.

SEC. 6223. HCFA PERSONNEL STUDY.

(a) **IN GENERAL.**—The Secretary of Health and Human Services shall (subject to subsection (c)) enter into an agreement with the National Academy of Public Administration (hereafter in this subsection referred to as the "Academy") to—

(1) study personnel administration at the Health Care Financing Administration (hereafter in this section referred to as "HCFA");

(2) assess the adequacy of HCFA staffing; and

(3) recommend any needed changes with respect to HCFA staffing to the Secretary of Health and Human Services and the Congress.

(b) **REQUIREMENTS OF STUDY.**—In conducting the study, the Academy shall interview management officials at HCFA and other appropriate agencies. The study shall include consideration of—

(1) the average years in service, years to retirement and average age of various categories of HCFA personnel;

(2) the adequacy of HCFA practices to recruit personnel to replace persons who retire or resign and train new employees in the intricacies of HCFA programs;

(3) the grade structure of various categories of HCFA personnel, and the need for additional nonsupervisory positions at the GS 13, 14, and 15 levels for particularly skilled and expert personnel needed for HCFA to carry out its missions;

(4) the grade structure at HCFA with Federal agencies of similar size and responsibilities;

(5) whether bonus payments or other incentives are needed for HCFA to recruit and retain specialized personnel;

(6) particular problems in hiring personnel that may prevent recruitment and retention of qualified staff;

(7) Office of Personnel Management rules that may be burdensome to the hiring process; and

(8) how HCFA can more appropriately address the priorities of both Congress and the executive branch of Government.

(c) **ARRANGEMENTS FOR STUDY.**—The Secretary shall request the National Academy of Sciences, acting through appropriate units, to submit an application to conduct the study described in this subsection. If the Academy submits an acceptable application, the Secretary shall enter into an appropriate arrangement with the Academy for the conduct of the study. If the Academy does not submit an acceptable application to conduct the study, the Secretary may request one or more appropriate nonprofit private entities to submit an application to conduct the study and may enter into an appropriate arrangement for the conduct of the study by the entity which submits the best acceptable application.

(d) **DATE OF REPORT.**—The results of the study shall be reported to Congress and the Secretary of Health and Human Services no later than December 31, 1990.

SEC. 6224. PEER REVIEW ORGANIZATIONS.

(a) **PEER REVIEW OF NON-PHYSICIAN SERVICES.**—

(1) **IN GENERAL.**—Section 1154(a)(1) of the Social Security Act (42 U.S.C. 1320c-3(a)(1)) is amended by adding at the end the following:

“If the organization performs such reviews with respect to a type of health care practitioner other than medical doctors, the organization shall establish procedures for the involvement of health care practitioners of that type in such reviews.”

(2) **EFFECTIVE DATE.**—The amendment made by paragraph (1) shall apply to contracts entered into after the date of the enactment of this Act.

(b) **PROVIDER AND PRACTITIONER RIGHT TO RECONSIDERATION OF PRO DETERMINATION BEFORE NOTICE TO BENEFICIARY.**—

(1) **IN GENERAL.**—Section 1154(a)(3) of the Social Security Act (42 U.S.C. 1320c-3(a)(3)) is amended—

(A) in subparagraph (A), by striking “subparagraph (B)” and inserting “subparagraphs (B) and (D)”,

(B) in subparagraph (B), by inserting “with respect to services or items disapproved by reason of subparagraph (A) or (C) of paragraph (1)” after “under subparagraph (A)”, and

(C) by adding at the end the following new subparagraphs:

“(D) The notification under subparagraph (A) with respect to services or items disapproved by reason of paragraph (1)(B) shall not occur until after—

“(i) the organization has notified the practitioner or provider involved of the determination and of the practitioner’s or provider’s right to a formal reconsideration of the determination under section 1155, and

“(ii) if the provider or practitioner requests such a reconsideration, the organization has made such a reconsideration.

If a provider or practitioner is provided a reconsideration, such reconsideration shall be in lieu of any subsequent reconsideration to which the provider or practitioner may be otherwise entitled under section 1155, but shall not affect the right of a beneficiary from seeking reconsideration under such section of the organization's determination (after any reconsideration requested by the provider or physician under clause (ii)).

“(E) In the case of services and items disapproved by reason of paragraph (1)(B), the notice to the patient shall state the following: ‘In the judgment of the peer review organization, the medical care received was not acceptable under the medicare program. The reasons for the denial have been discussed with your physician and hospital.’”

(2) CONFORMING AMENDMENT.—Section 1155 of such Act (42 U.S.C. 1320c-5) is amended by inserting “, subject to section 1154(a)(3)(D),” before “any practitioner or provider”.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to determinations by utilization and quality control peer review organizations with respect to which preliminary notifications were made under section 1154(a)(3)(B) of the Social Security Act more than 30 days after the date of the enactment of this Act.

PART 4—PART B PREMIUM

SEC. 6301. PART B PREMIUM.

Section 1839(e) of the Social Security Act (42 U.S.C. 1395r(e)) is amended by striking “1990” each place it appears and inserting “1991”

Subtitle B—Medicaid

PART 1—GENERAL PROVISIONS

SEC. 6401. MANDATORY COVERAGE OF CERTAIN LOW-INCOME PREGNANT WOMEN AND CHILDREN.

(a) IN GENERAL.—Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended—

(1) in subsection (a)(10)(A)(i)—

(A) by striking “or” at the end of subclause (IV),

(B) by striking the semicolon at the end of subclause (V) and inserting “, or”, and

(C) by adding at the end the following new subclause:

“(VI) who are described in subparagraph (C) of subsection (1)(1) and whose family income does not exceed the income level the State is required to establish under subsection (1)(2)(B) for such a family;”;

(2) in subsection (a)(10)(A)(ii)(IX), by inserting “or clause (i)(VI)” after “clause (i)(IV)”;

(3) in subsection (1)(1)—

(A) by striking “and” at the end of subparagraph (B), and

(B) by striking subparagraph (C) and inserting the following:

“(C) who have attained one year of age but have not attained 6 years of age, and

“(D) at the option of the State, children born after September 30, 1983, who have attained 6 years of age but have not attained 7 or 8 years of age (as selected by the State),”;

(4) in subsection (1)(2)(A)—

(A) in clause (ii), by amending subclause (II) to read as follows:

“(II) April 1, 1990, 133 percent, or, if greater, the percentage provided under clause (iv).”; and

(B) by adding at the end the following new clause:

“(iv) In the case of a State which, as of the date of the enactment of this clause, has established under clause (i), or has enacted legislation authorizing, or appropriating funds, to provide for, a percentage (of the income official poverty line) that is greater than 133 percent, the percentage provided under clause (ii) for medical assistance on or after April 1, 1990, shall not be less than—

“(I) the percentage specified by the State in an amendment to its State plan (whether approved or not) as of the date of the enactment of this clause, or

“(II) if no such percentage is specified as of the date of the enactment of this clause, the percentage established under the State’s authorizing legislation or provided for under the State’s appropriations.”;

(5) in subparagraph (B) of subsection (1)(2)—

(A) by striking “, or , if less, the percentage established under subparagraph (A)”, and

(B) by redesignating such subparagraph as subparagraph (C);

(6) in subsection (1)(2), by inserting after subparagraph (A) the following new subparagraph:

“(B) For purposes of paragraph (1) with respect to individuals described in subparagraph (C), the State shall establish an income level which is equal to 133 percent of the income official poverty line described in subparagraph (A) applicable to a family of the size involved.”;

(6) in subsection (1)(3)—

(A) by inserting “, (a)(10)(A)(i)(VI),” after “(a)(10)(A)(i)(IV)”, and

(B) in subparagraph (C), by striking “or (C)” and inserting “, (C), or (D)”;

(7) in subsection (1)(4)—

(A) in subparagraph (A), by inserting “and for children described in subsection (a)(10)(A)(i)(VI)” after “(a)(10)(A)(i)(IV)”, and

(B) in subparagraph (B), by inserting “or (a)(10)(A)(i)(VI)” after “(a)(10)(A)(i)(IV)”;

(8) in subsection (e)(7), by striking “or (C)” and inserting “, (C) or (D)”;

(9) in subsection (r)(2)(A), by inserting “(a)(10)(A)(i)(VI),” after “(a)(10)(A)(i)(IV),”.

(b) **CONFORMING AMENDMENT.**—Section 1903(f)(4) of such Act (42 U.S.C. 1396b(f)(4)) is amended by inserting “1902(a)(10)(A)(i)(VI),” after “1902(a)(10)(A)(i)(IV),”.

(c) **EFFECTIVE DATE.**—

(1) Except as provided in paragraph (2), the amendments made by this section shall apply to payments under title XIX of the Social Security Act for calendar quarters beginning on or after April 1, 1990, with respect to eligibility for medical assistance on or after such date, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

SEC. 6402. PAYMENT FOR OBSTETRICAL AND PEDIATRIC SERVICES.

(a) **CODIFICATION OF ADEQUATE PAYMENT LEVEL PROVISIONS.**—Section 1902(a)(30)(A) of the Social Security Act (42 U.S.C. 1396a(a)(30)(A)) is amended by inserting before the semicolon at the end the following: “and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area”.

(b) **ASSURING ADEQUATE PAYMENT LEVELS FOR OBSTETRICAL AND PEDIATRIC SERVICES.**—Title XIX of such Act, as amended by section 303 of the Family Support Act of 1988, is amended by redesignating section 1926 as section 1927 and by inserting after section 1925 the following new section:

“ASSURING ADEQUATE PAYMENT LEVELS FOR OBSTETRICAL AND PEDIATRIC SERVICES

“SEC. 1926. (a)(1) A State plan under this title shall not be considered to meet the requirement of section 1902(a)(30)(A) with respect to obstetrical services (as defined in paragraph (4)(A)), as of July 1 of each year (beginning with 1990), unless, by not later than April 1 of such year, the State submits to the Secretary an amendment to the plan that specifies the payment rates to be used for such services under the plan in the succeeding period and includes in such submission such additional data as will assist the Secretary in evaluating the State’s compliance with such requirement, including data relating to how rates established for payments to health mainte-

nance organizations under section 1903(m) take into account such payment rates.

"(2) A State plan under this title shall not be considered to meet the requirement of section 1902(a)(30)(A) with respect to pediatric services (as defined in paragraph (4)(B)), as of July 1 of each year (beginning with 1990), unless, by not later than April 1 of such year, the State submits to the Secretary an amendment to the plan that specifies, by pediatric procedure, the payment rates to be used for such services under the plan in the succeeding period and includes in such submission such additional data as will assist the Secretary in evaluating the State's compliance with such requirement, including data relating to how rates established for payments to health maintenance organizations under section 1903(m) take into account such payment rates.

"(3) The Secretary, by not later than 90 days after the date of submission of a plan amendment under paragraph (1) or (2), shall—

"(A) review each such amendment for compliance with the requirement of section 1902(a)(30)(A), and

"(B) approve or disapprove each such amendment.

If the Secretary disapproves such an amendment, the State shall immediately submit a revised amendment which meets such requirement.

"(4) In this section:

"(A) The term 'obstetrical services' means services relating to pregnancy covered under the State plan provided by an obstetrician, obstetrician-gynecologist, family practitioner, certified nurse midwife, or certified family nurse practitioner and does not include inpatient or outpatient hospital services or other institutional services.

"(B) The term 'pediatric services' means services covered under the State plan provided by a pediatrician, family practitioner, or certified pediatric nurse practitioner to children under 18 years of age and does not include inpatient or outpatient hospital services or other institutional services.

"(b) For amendments submitted under subsection (a)(1) in 1992 and thereafter, the data submitted under such subsection must include, for the second previous year, at least the statewide average payment rates under the State plan for obstetrical services furnished by obstetricians, obstetrician-gynecologists, family practitioners, certified family nurse practitioners, and certified nurse midwives, by procedure. Such information shall be provided separately for providers located in each metropolitan statistical area (or similar area) in the State and in the remainder of the State.

"(c) For amendments submitted under subsection (a)(2) in 1992 and thereafter, the data submitted under such subsection must include, for the second previous year, at least the statewide average payment rates under the State plan for pediatric services furnished by pediatricians, family practitioners, and certified pediatric nurse practitioners by procedure. Such information shall be provided separately for providers located in each metropolitan statistical area (or similar area) in the State and in the remainder of the State.

"(d) Nothing in this title (including section 1902(a)(30)(A)) shall be construed as preventing a State from establishing payment levels for obstetrical or pediatric services that are higher for those services

furnished in rural areas than those furnished in metropolitan statistical areas.”

(c) PAYMENT FOR CERTAIN SERVICES IN CERTAIN FEDERALLY-FUNDED HEALTH CENTERS.—

(1) **COVERAGE.**—Section 1905(a)(2) of the Social Security Act (42 U.S.C. 1396d(a)(2)) is amended by striking “and” before “(B)” and by inserting before the semicolon at the end the following: “, and (C) ambulatory services offered by a health center receiving funds under section 329, 330, or 340 of the Public Health Service Act to a pregnant woman or individual under 18 years of age”.

(2) **PAYMENT AMOUNTS.**—Section 1902(a)(13)(E) of such Act (42 U.S.C. 1396a(a)(13)(E)) is amended by inserting “, and for payment for services described in section 1905(a)(2)(C) under the plan,” after “provided by a rural health clinic under the plan”.

(d) **EFFECTIVE DATE.**—(1) The amendments made by subsections (a) and (b) (except as otherwise provided in such amendments) shall take effect on the date of the enactment of this Act.

(2)(A) The amendments made by subsection (c) apply (except as provided under subparagraph (B)) to payments under title XIX of the Social Security Act for calendar quarters beginning on or after July 1, 1990, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

(B) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by subsection (c), the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

SEC. 6403. EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT SERVICES DEFINED.

(a) **IN GENERAL.**—Section 1905 of the Social Security Act (42 U.S.C. 1396d) is amended by adding at the end the following new subsection:

“(r) The term ‘early and periodic screening, diagnostic, and treatment services’ means the following items and services:

“(1) Screening services—

“(A) which are provided—

“(i) at intervals which meet reasonable standards of medical and dental practice, as determined by the State after consultation with recognized medical and dental organizations involved in child health care, and

“(ii) at such other intervals, indicated as medically necessary, to determine the existence of certain physical or mental illnesses or conditions; and

“(B) which shall at a minimum include—

“(i) a comprehensive health and developmental history (including assessment of both physical and mental health development),

“(ii) a comprehensive unclothed physical exam,

“(iii) appropriate immunizations according to age and health history,

“(iv) laboratory tests (including lead blood level assessment appropriate for age and risk factors), and

“(v) health education (including anticipatory guidance).

“(2) Vision services—

“(A) which are provided—

“(i) at intervals which meet reasonable standards of medical practice, as determined by the State after consultation with recognized medical organizations involved in child health care, and

“(ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and

“(B) which shall at a minimum include diagnosis and treatment for defects in vision, including eyeglasses.

“(3) Dental services—

“(A) which are provided—

“(i) at intervals which meet reasonable standards of dental practice, as determined by the State after consultation with recognized dental organizations involved in child health care, and

“(ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and

“(B) which shall at a minimum include relief of pain and infections, restoration of teeth, and maintenance of dental health.

“(4) Hearing services—

“(A) which are provided—

“(i) at intervals which meet reasonable standards of medical practice, as determined by the State after consultation with recognized medical organizations involved in child health care, and

“(ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and

“(B) which shall at a minimum include diagnosis and treatment for defects in hearing, including hearing aids.

“(5) Such other necessary health care, diagnostic services, treatment, and other measures described in section 1905(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan.

Nothing in this title shall be construed as limiting providers of early and periodic screening, diagnostic, and treatment services to providers who are qualified to provide all of the items and services described in the previous sentence or as preventing a provider that is

qualified under the plan to furnish one or more (but not all) of such items or services from being qualified to provide such items and services as part of early and periodic screening, diagnostic, and treatment services. ”.

(b) **REPORT ON PROVISION OF EPSDT.**—Section 1902(a)(43) of such Act (42 U.S.C. 1396a(a)(43)) is amended—

- (1) by striking “and” at the end of subparagraph (B),
- (2) by striking the semicolon at the end of subparagraph (C) and inserting “, and”, and
- (3) by adding at the end the following new subparagraph:

“(D) reporting to the Secretary (in a uniform form and manner established by the Secretary, by age group and by basis of eligibility for medical assistance, and by not later than April 1 after the end of each fiscal year, beginning with fiscal year 1990) the following information relating to early and periodic screening, diagnostic, and treatment services provided under the plan during each fiscal year:

“(i) the number of children provided child health screening services,

“(ii) the number of children referred for corrective treatment (the need for which is disclosed by such child health screening services),

“(iii) the number of children receiving dental services, and

“(iv) the State’s results in attaining the participation goals set for the State under section 1905(r);”.

(c) **ANNUAL PARTICIPATION GOALS.**—Section 1905(r) of such Act, as added by subsection (a), is amended by adding at the end the following: “The Secretary shall, not later than July 1, 1990, and every 12 months thereafter, develop and set annual participation goals for each State for participation of individuals who are covered under the State plan under this title in early and periodic screening, diagnostic, and treatment services.”.

(d) **CONFORMING AMENDMENTS.**—(1) Section 1902(a)(43)(A) of such Act (42 U.S.C. 1396a(a)(43)(A)) is amended by striking “and treatment services as described in section 1905(a)(4)(B)” and inserting “and treatment services as described in section 1905(r)”.

(2) Section 1905(a)(4) of such Act (42 U.S.C. 1396d(a)(4)) is amended by amending clause (B) to read as follows: “(B) early and periodic screening, diagnostic, and treatment services (as defined in subsection (r)) for individuals who are eligible under the plan and are under the age of 21; and”.

(e) **EFFECTIVE DATE.**—The amendments made by this section shall take effect on April 1, 1990, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

SEC. 6404. PAYMENT FOR FEDERALLY-QUALIFIED HEALTH CENTER SERVICES.

(a) **COVERAGE.**—Section 1905(a)(2) of the Social Security Act (42 U.S.C. 1396d(a)(2)) is amended—

- (1) by striking “and” before “(B)”,
- (2) by striking “subsection (l)” and inserting “subsection (l)(1)”, and

(3) by inserting before the semicolon at the end the following: “, and (C) Federally-qualified health center services (as defined in subsection (1)(2)) and any other ambulatory services offered by a Federally-qualified health center and which are otherwise included in the plan”.

(b) **TERMS DEFINED.**—Section 1905(l) of such Act is amended—

(1) by redesignating clauses (1) and (2) as clauses (A) and (B),

(2) by inserting “(1)” after “(l)”, and

(3) by adding at the end the following new paragraph:

“(2)(A) The term ‘Federally qualified health center services’ means services of the type described in subparagraphs (A) through (C) of section 1861(aa)(1) when furnished to an individual as an outpatient of a Federally qualified health center and, for this purpose, any reference to a rural health clinic or a physician described in section 1861(aa)(2)(B) is deemed a reference to a Federally qualified health center or a physician at the center, respectively.

“(B) The term ‘Federally qualified health center’ means a facility which—

“(i) is receiving a grant under section 329, 330, or 340 of the Public Health Service Act, or

“(ii) based on the recommendation of the Health Resources and Services Administration within the Public Health Service, is determined by the Secretary to meet the requirements for receiving such a grant.

In applying clause (ii), the Secretary may waive any requirement referred to in such clause for up to 2 years for good cause shown.”.

(c) **PAYMENT AMOUNTS.**—Section 1902(a)(13)(E) of such Act (42 U.S.C. 1396a(a)(13)(E)) is amended by striking “section 1905(a)(2)(B) provided by a rural health clinic” and inserting “clause (B) or (C) of section 1905(a)(2)”.

(d) **EFFECTIVE DATE.**—(1) The amendments made by this section apply (except as provided under paragraph (2)) to payments under title XIX of the Social Security Act for calendar quarters beginning on or after April 1, 1990, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

SEC. 6405. REQUIRED COVERAGE OF NURSE PRACTITIONER SERVICES.

(a) **IN GENERAL.**—Section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)) is amended—

- (1) in paragraph (20), by striking "and";
- (2) by redesignating paragraph (21) as paragraph (22); and
- (3) by inserting at the end of paragraph (20) the following new paragraph:

"(21) services furnished by a certified pediatric nurse practitioner or certified family nurse practitioner (as defined by the Secretary) which the certified pediatric nurse practitioner or certified family nurse practitioner is legally authorized to perform under State law (or the State regulatory mechanism provided by State law), whether or not the certified pediatric nurse practitioner or certified family nurse practitioner is under the supervision of, or associated with, a physician or other health care provider;"

(b) **CONFORMING AMENDMENT.**—Section 1902(a)(10)(A) of such Act (42 U.S.C. 1396a(a)(10)(A)) is amended by striking "(1) through (5) and (17)" and by inserting in lieu thereof "(1) through (5), (17) and (21)".

(c) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall become effective with respect to services furnished by a certified pediatric nurse practitioner or certified family nurse practitioner on or after July 1, 1990.

SEC. 6406. REQUIRED MEDICAID NOTICE AND COORDINATION WITH SPECIAL SUPPLEMENTAL FOOD PROGRAM FOR WOMEN, INFANTS, AND CHILDREN (WIC).

(a) **STATE PLAN REQUIREMENTS OF NOTICE AND COORDINATION.**—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended—

(1) in paragraph (11), by striking "and" before "(B)" and by inserting before the semicolon at the end the following: "; and (C) provide for coordination of the operations under this title with the State's operations under the special supplemental food program for women, infants, and children under section 17 of the Child Nutrition Act of 1966";

(2) by striking "and" at the end of paragraph (51);

(3) by striking the period at the end of paragraph (52) and inserting "; and"; and

(4) by inserting after paragraph (52) the following new paragraph:

"(53) provide—

"(A) for notifying in a timely manner all individuals in the State who are determined to be eligible for medical assistance and who are pregnant women, breastfeeding or postpartum women (as defined in section 17 of the Child Nutrition Act of 1966), or children below the age of 5, of the availability of benefits furnished by the special supplemental food program under such section, and

"(B) for referring any such individual to the State agency responsible for administering such program."

(b) **EFFECTIVE DATE.**—The amendments made by subsection (a) shall take effect on July 1, 1990, without regard to whether regulations to carry out such amendments have been promulgated by such date.

SEC. 6407. DEMONSTRATION PROJECTS TO STUDY THE EFFECT OF ALLOWING STATES TO EXTEND MEDICAID TO PREGNANT WOMEN AND CHILDREN NOT OTHERWISE QUALIFIED TO RECEIVE MEDICAID BENEFITS.

(a) **IN GENERAL.**—In order to allow States to develop and carry out innovative programs to extend health insurance coverage to pregnant women and children under age 20 who lack insurance and to encourage workers to obtain health insurance for themselves and their children, the Secretary of Health and Human Services (in this section referred to as the “Secretary”) shall enter into agreements with several States submitting applications in accordance with subsection (b) for the purpose of conducting demonstration projects to study the effect on access to health care, private insurance coverage, and costs of health care when such States are allowed to extend benefits under title XIX of the Social Security Act, either directly, in the same manner, or otherwise as alternative assistance authorized in section 1925(b)(4)(D) of such Act, to pregnant women and children under 20 who are not otherwise qualified to receive benefits under such section.

(b) **PROJECT REQUIREMENTS.**—(1) Each State applying to participate in the demonstration project under subsection (a) shall assure the Secretary that eligibility shall be limited to pregnant women and children who have not attained 20 years of age who are in families with income below 185 percent of the income official poverty line (referred to in subsection (c)(1)).

(2) The Secretary shall further provide in conducting demonstration projects under this section that if one or more of such demonstration projects utilizes employer coverage as allowed under section 1925(b)(4)(D) of the Social Security Act that such project shall require an employer contribution.

(c) **PREMIUMS.**—In the case of pregnant women and children eligible to participate in such demonstration projects whose family income level is—

(1) below 100 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved, there shall be no premium charged; and

(2) between 100 and 185 percent of such income official poverty line, there shall be a premium equal to—

(A) an amount based on a sliding scale relating to income, or

(B) 3 percent of the family’s average gross monthly earnings,

whichever is less.

(d) **DURATION.**—Each demonstration project under this section shall be conducted for a period not to exceed 3 years.

(e) **WAIVER.**—The Secretary where he deems appropriate may waive the statewideness requirement described in section 1902(a)(1).

(f) **LIMIT ON EXPENDITURES.**—The Secretary in conducting the demonstration projects described in this section shall limit the amount of the Federal share of benefits paid and expenses incurred under title XIX of the Social Security Act to \$10,000,000 in each of fiscal years 1990, 1991, and 1992.

(g) **EVALUATION AND REPORT.**—(1) For each demonstration project conducted under this section, the Secretary shall assure that an evaluation is conducted on the effect of the project with respect to—

- (A) access to health care;
- (B) private health care insurance coverage;
- (C) costs with respect to health care; and
- (D) developing feasible premium and cost-sharing policies.

(2) The Secretary shall submit to Congress an interim report containing a summary of the evaluations conducted under paragraph (1) not later than January 1, 1992, and a final report containing such summary together with such further recommendations as the Secretary may determine appropriate not later than January 1, 1994.

SEC. 6408. OTHER MEDICAID PROVISIONS.

(a) **INSTITUTIONS FOR MENTAL DISEASES.**—

(1) **STUDY.**—The Secretary of Health and Human Services shall conduct a study of—

(A) the implementation, under current provisions, regulations, guidelines, and regulatory practices under title XIX of the Social Security Act, of the exclusion of coverage of services to certain individuals residing in institutions for mental diseases, and

(B) the costs and benefits of providing services under title XIX of the Social Security Act in public subacute psychiatric facilities which provide services to psychiatric patients who would otherwise require acute hospitalization.

(2) **REPORT.**—By not later than October 1, 1990, the Secretary shall submit a report to Congress on the study and shall include in the report recommendations respecting—

(A) modifications in such provisions, regulations, guidelines, and practices, if any, that may be appropriate to accommodate changes that may have occurred since 1972 in the delivery of psychiatric and other mental health services on an inpatient basis to such individuals, and

(B) the continued coverage of services provided in subacute psychiatric facilities under title XIX of the Social Security Act.

(3) **MORATORIUM ON TREATMENT OF CERTAIN FACILITIES.**—Any determination by the Secretary that Kent Community Hospital Complex in Michigan or Saginaw Community Hospital in Michigan is an institution for mental diseases, for purposes of title XIX of the Social Security Act shall not take effect until 180 days after the date the Congress receives the report required under paragraph (2).

(b) **EXTENSION OF TEXAS PERSONAL CARE SERVICES WAIVER.**—Section 9523(a) of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended by section 4115(d) of the Omnibus Budget Reconciliation Act of 1987 (added by section 411(k)(9)(C) of the Medicare Catastrophic Coverage Act of 1988), is amended by striking “January 1, 1990” and inserting “July 1, 1990”.

(c) **HOSPICE PAYMENT FOR ROOM AND BOARD.**—

(1) **IN GENERAL.**—Section 1902(a)(13)(D) of the Social Security Act (42 U.S.C. 1396a(a)(13)(D)) is amended—

(A) by striking “in the same amounts, and using the same methodology, as used” and inserting “in amounts no lower than the amounts, using the same methodology, used”, and

(B) by striking “a separate rate may be paid for” and inserting “in the case of”, and

(C) by striking “to take into account the room and board furnished by such facility” and inserting “there shall be paid an additional amount, to take into account the room and board furnished by the facility, equal to at least 95 percent of the rate that would have been paid by the State under the plan for facility services in that facility for that individual”.

(2) *EFFECTIVE DATE.*—The amendments made by paragraph (1) shall apply to services furnished on or after April 1, 1990, without regard to whether or not final regulations have been promulgated by such date to implement such amendments.

(d) *MEDICARE BUY-IN FOR PREMIUMS OF CERTAIN WORKING DISABLED.*—

(1) *IN GENERAL.*—Section 1902(a)(10)(E) of the Social Security Act (42 U.S.C. 1396a(a)(10)(E)), as amended by 6403(a) of this subtitle, is amended—

(A) by inserting “(i)” after “(E)”,

(B) by striking the semicolon at the end and inserting “, and”, and

(C) by adding at the end the following new clause:

“(ii) for making medical assistance available for payment of medicare cost-sharing described in section 1905(p)(3)(A)(i) for qualified disabled and working individuals described in section 1905(t);”.

(2) *ELIGIBILITY.*—Section 1905 of such Act (42 U.S.C. 1396d), as amended by section 6403(a) of this subtitle, is amended by adding at the end the following new subsection:

“(s) The term ‘qualified disabled and working individual’ means an individual—

“(1) who is entitled to enroll for hospital insurance benefits under part A of title XVIII under section 1818A (as added by 6012 of the Omnibus Budget Reconciliation Act of 1989);

“(2) whose income (as determined under section 1612 for purposes of the supplemental security income program) does not exceed 200 percent of the official poverty line (as defined by the Office of Management and Budget and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved;

“(3) whose resources (as determined under section 1613 for purposes of the supplemental security income program) do not exceed twice the maximum amount of resources that an individual or a couple (in the case of an individual with a spouse) have and obtain benefits for supplemental security income benefits under title XVI; and

“(4) who is not otherwise eligible for medical assistance under this title.”

(3) **PREMIUM PAYMENTS REQUIRED FOR CERTAIN INDIVIDUALS.**—Section 1916 of such Act (42 U.S.C. 1396o) is amended—

(A) in subsection (a), by striking “(E)” and inserting “(E)(i)”,

(B) by redesignating subsections (d) and (e) as subsections (e) and (f), respectively, and

(C) by inserting after subsection (c) the following new subsection:

“(d) With respect to a qualified disabled and working individual described in section 1905(s) whose income (as determined under paragraph (3) of that section) exceeds 150 percent of the official poverty line referred to in that paragraph, the State plan of a State may provide for the charging of a premium (expressed as a percentage of the medicare cost-sharing described in section 1905(p)(3)(A)(i) provided with respect to the individual) according to a sliding scale under which such percentage increases from 0 percent to 100 percent, in reasonable increments (as determined by the Secretary), as the individual’s income increases from 150 percent of such poverty line to 200 percent of such poverty line.”.

(4) **CONFORMING AMENDMENTS.**—

(A) Section 1905(p)(3) of such Act (42 U.S.C. 1396d(p)(3)) is amended—

(i) by amending subparagraph (A) to read as follows:

“(A)(i) premiums under section 1818, and

“(ii) premiums under section 1839,” and

(ii) in subparagraph (A), by striking “section 1818” and inserting “section 1818 or 1818A”.

(B) Section 1905(p)(1)(A) of such Act is amended by inserting “, but not including an individual entitled to such benefits only pursuant to an enrollment under section 1818A” after “1818”.

(C) Section 1902(f) of such Act (42 U.S.C. 1396a(f)) is amended by inserting “, except with respect to qualified disabled and working individuals (described in section 1905(s),” after “1619(b)(3)”.

(5) **EFFECTIVE DATE.**—

(A) The amendments made by this subsection apply (except as provided under subparagraph (B)) to payments under title XIX of the Social Security Act for calendar quarters beginning on or after July 1, 1990, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

(B) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by this subsection, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For pur-

poses of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

PART 2—TECHNICAL AND MISCELLANEOUS PROVISIONS

SEC. 6411. MISCELLANEOUS MEDICAID TECHNICAL AMENDMENTS.

(a) TECHNICAL CORRECTION TO MEDICARE BUY-IN FOR THE ELDERLY.—

(1) **CLARIFICATION WITH RESPECT TO “SECTION 209(B)” STATES.**—The first sentence of section 1902(f) of the Social Security Act (42 U.S.C. 1396a(f)) is amended by inserting “and except with respect to qualified medicare beneficiaries, qualified severely impaired individuals, and individuals described in subsection (m)(1)” before “, no State”.

(2) **EFFECTIVE DATE.**—The amendment made by paragraph (1) shall apply as if it had been included in the enactment of the Medicare Catastrophic Coverage Act of 1988.

(b) **EXTENSION OF DELAY IN ISSUANCE OF CERTAIN FINAL REGULATIONS.**—Section 8431 of the Technical and Miscellaneous Revenue Act of 1988 is amended by striking “May 1, 1989” and inserting “December 31, 1990”.

(c) DISPROPORTIONATE SHARE HOSPITALS.—

(1) **SPECIAL RULE FOR NEW JERSEY UNCOMPENSATED CARE TRUST FUND.**—Section 1923(e)(1) of the Social Security Act (42 U.S.C. 1396r-4(e)(1)) is amended—

(A) by inserting “(A)(i)” after “without regard to the requirement of subsection (a) if”, and

(B) by striking “and if” and inserting “or (ii) the plan as of January 1, 1987, provided for payment adjustments based on a statewide pooling arrangement involving all acute care hospitals and the arrangement provides for reimbursement of the total amount of uncompensated care provided by each participating hospital, and (B)”.

(2) **CONFORMING AMENDMENT.**—Section 1915(b)(4) of such Act (42 U.S.C. 1396n(b)(4)) is amended by inserting “shall be consistent with the requirements of section 1923 and” after “which standards”.

(3) **TRANSITION RULE.**—The State of Missouri shall be treated as having met the requirement of section 1902(a)(13)(A) of the Social Security Act (insofar as it requires payments to hospitals to take into account the situation of hospitals that serve a disproportionate number of low-income patients with special needs) for the period beginning with July 1, 1988, and ending with (and including) June 30, 1990, if the total amount of such payments for such period is not less than the total of such payments otherwise required by law for such period.

(4) **EFFECTIVE DATE.**—The amendment made by paragraph (2) shall be effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1987.

(d) FRAUD AND ABUSE TECHNICAL AMENDMENTS.—

(1) **TREATMENT OF LOSS OF RIGHT TO RENEW LICENSE.**—Section 1128(b)(4)(A) of the Social Security Act (42 U.S.C. 1396a-7(b)(4)(A)) is amended by inserting “or the right to apply for or renew such a license” after “lost such a license”.

(2) **CLARIFICATION WITH RESPECT TO EMERGENCY TREATMENT.**—Sections 1862(e)(1) and 1903(i)(2) of such Act (42 U.S.C. 1395y(e)(1), 1396b(i)(2)) are each amended by inserting “, not including items or services furnished in an emergency room of a hospital” after “emergency item or service”.

(3) **CLARIFICATION OF EXCLUSION WITH RESPECT TO EMPLOYMENT BY HEALTH MAINTENANCE ORGANIZATIONS.**—(A) Section 1876(i)(6)(A) of the Social Security Act (42 U.S.C. 1395mm(i)(6)(A)) is amended—

(i) by striking “or” at the end of clause (v),

(ii) by adding “or” at the end of clause (vi), and

(iii) by inserting after clause (vi) the following new clause:

“(vii) in the case of a risk-sharing contract, employs or contracts with any individual or entity that is excluded from participation under this title under section 1128 or 1128A for the provision of health care, utilization review, medical social work, or administrative services or employs or contracts with any entity for the provision (directly or indirectly) through such an excluded individual or entity of such services;”.

(B) Section 1902(p)(2) of Act (42 U.S.C. 1396a(p)(2)) is amended—

(i) by striking “or” at the end of subparagraph (A),

(ii) by striking the period at the end of subparagraph (B) and inserting “, or”, and

(iii) by adding at the end the following new subparagraph:

“(C) employs or contracts with any individual or entity that is excluded from participation under this title under section 1128 or 1128A for the provision of health care, utilization review, medical social work, or administrative services or employs or contracts with any entity for the provision (directly or indirectly) through such an excluded individual or entity of such services.”.

(4) **EFFECTIVE DATES.**—The amendments made by paragraphs (1) and (2) shall take effect on the date of the enactment of this Act.

(B) The amendments made by paragraph (3) shall apply to employment and contracts as of 90 days after the date of the enactment of this Act.

(e) **SPOUSAL IMPOVERISHMENT.**—

(1) **EQUAL TREATMENT OF TRANSFERS BY COMMUNITY SPOUSE BEFORE INSTITUTIONALIZATION.**—Section 1917(c) of the Social Security Act (42 U.S.C. 1396p(c)) is amended—

(A) in paragraph (1), by inserting “or whose spouse,” after “an institutionalized individual (as defined in paragraph (3)) who,” and

(B) in paragraph (2)(B)—

(i) by amending clause (i) to read as follows: "(i) to or from (or to another for the sole benefit of) the individual's spouse, or", and

(ii) by striking "; or (iii)" and all that follows through "fair market value".

(2) **CLARIFYING APPLICATION TO "SECTION 209(B)" STATES.**—Section 1902(f) of such Act (42 U.S.C. 1396a(f)) is amended by inserting "and section 1924" after "1619(b)(3)".

(3) **CLARIFICATION OF APPLICATION OF INCOME RULES TO REDETERMINATIONS.**—Subsections (b)(2) and (d) of section 1924 of such Act are amended by inserting "or redetermined" after "determined".

(4) **EFFECTIVE DATES.**—

(A) **SPOUSAL TRANSFERS.**—The amendments made by paragraph (1) shall apply to transfers occurring after the date of the enactment of this Act.

(B) **OTHER AMENDMENTS.**—Except as provided in subparagraph (A), the amendments made by this subsection shall apply as if included in the enactment of section 303 of the Medicare Catastrophic Coverage Act of 1988.

(f) **EXTENSION OF WAIVER FOR HEALTH INSURING ORGANIZATION.**—The Secretary of Health and Human Services shall continue to waive, through June 30, 1992, the application of section 1903(m)(2)(A)(ii) of the Social Security Act to the Tennessee Primary Care Network, Inc., under the same terms and conditions as applied to such waiver as of July 1, 1989.

(g) **DAY HABILITATION AND RELATED SERVICES.**—

(1) **PROHIBITION OF DISALLOWANCE PENDING ISSUANCE OF REGULATIONS.**—Except as specifically permitted under paragraph (3), the Secretary of Health and Human Services may not—

(A) withhold, suspend, disallow, or deny Federal financial participation under section 1903(a) of the Social Security Act for day habilitation and related services under paragraph (9) or (13) of section 1905(a) of such Act on behalf of persons with mental retardation or with related conditions pursuant to a provision of its State plan as approved on or before June 30, 1989, or

(B) withdraw Federal approval of any such State plan provision.

(2) **REQUIREMENTS FOR REGULATION.**—A final regulation described in this paragraph is a regulation, promulgated after a notice of proposed rule-making and a period of at least 60 days for public comment, that—

(A) specifies the types of day habilitation and related services that a State may cover under paragraph (9) or (13) of section 1905(a) of the Social Security Act on behalf of persons with mental retardation or with related conditions, and

(B) any requirements respecting such coverage.

(3) **PROSPECTIVE APPLICATION OF REGULATION.**—If the Secretary promulgates a final regulation described in paragraph (2) and the Secretary determines that a State plan under title XIX of the Social Security Act does not comply with such regulation, the Secretary shall notify the State of the determination and its

basis, and such determination shall not apply to day habilitation and related services furnished before the first day of the first calendar quarter beginning after the date of the notice to the State.

(h) **MORATORIUM ON ISSUANCE OF FINAL REGULATION ON MEDICALLY NEEDY INCOME LEVELS FOR CERTAIN 1-MEMBER FAMILIES.**—The Secretary of Health and Human Services may not issue in final form, before December 31, 1990, any regulation implementing the proposed regulation published on September 26, 1989 (54 Federal Register 39421) insofar as such regulation changes the method for establishing the medically needy income level for single individuals in any State (including the proposed change to section 435.1007(a)(1) to title 42, Code of Federal Regulations).

(i) **TECHNICAL CORRECTIONS CONCERNING TRANSITIONAL COVERAGE.**—

(1) **CLARIFICATION OF TERMINATION WHEN NO CHILD IN HOUSEHOLD.**—Subsections (a)(3)(A) and (b)(3)(A)(i) of section 1925 of the Social Security Act (42 U.S.C. 1396r-6) are each amended by striking “who is” and inserting “, whether or not the child is”.

(2) **EFFECTIVE DATE FOR TERMINATION OF CURRENT 9-MONTH EXTENSION.**—Section 303(f)(2)(A) of the Family Support Act of 1988 is amended by inserting before the period at the end the following: “, but such amendment shall not apply with respect to families that cease to be eligible for aid under part A of title IV of the Social Security Act before such date”.

(3) **CORRECTION OF REFERENCES.**—Subsections (a)(3)(C) and (b)(3)(C)(i) of section 1925 of the Social Security Act (42 U.S.C. 1396r-6) are each amended by striking “or (v) of section 1905(a)” and inserting “of section 1905(a) or clause (i)(IV), (i)(VI), or (ii)(IX) of section 1902(a)(10)(A)”.

(4) **EFFECTIVE DATE.**—The amendments made by this section shall be effective as if included in the enactment of the Family Support Act of 1988.

(j) **MINNESOTA PREPAID MEDICAID DEMONSTRATION PROJECT EXTENSION.**—Section 507 of the Family Support Act of 1988 is amended by striking “1990” and inserting “1991”.

Subtitle C—Maternal and Child Health Block Grant Program

SEC. 6501. INCREASE IN AUTHORIZATION OF APPROPRIATIONS.

(a) **IN GENERAL.**—Section 501 of the Social Security Act (42 U.S.C. 701) is amended—

(1) by amending subsection (a) to read as follows:

“(a) To improve the health of all mothers and children consistent with the applicable health status goals and national health objectives established by the Secretary under the Public Health Service Act for the year 2000, there are authorized to be appropriated \$686,000,000 for fiscal year 1990 and each fiscal year thereafter—

“(1) for the purpose of enabling each State—

“(A) to provide and to assure mothers and children (in particular those with low income or with limited availabil-

ity of health services) access to quality maternal and child health services;

“(B) to reduce infant mortality and the incidence of preventable diseases and handicapping conditions among children, to reduce the need for inpatient and long-term care services, to increase the number of children (especially preschool children) appropriately immunized against disease and the number of low income children receiving health assessments and follow-up diagnostic and treatment services, and otherwise to promote the health of mothers and infants by providing prenatal, delivery, and postpartum care for low income, at-risk pregnant women, and to promote the health of children by providing preventive and primary care services for low income children;

“(C) to provide rehabilitation services for blind and disabled individuals under the age of 16 receiving benefits under title XVI, to the extent medical assistance for such services is not provided under title XIX; and

“(D) to provide and to promote family-centered, community-based, coordinated care (including care coordination services, as defined in subsection (b)(3)) for children with special health care needs and to facilitate the development of community-based systems of services for such children and their families;

“(2) for the purpose of enabling the Secretary (through grants, contracts, or otherwise) to provide for special projects of regional and national significance, research, and training with respect to maternal and child health and children with special health care needs (including early intervention training and services development), for genetic disease testing, counseling, and information development and dissemination programs, for grants (including funding for comprehensive hemophilia diagnostic treatment centers) relating to hemophilia without regard to age, and for the screening of newborns for sickle cell anemia, and other genetic disorders and follow-up services; and

“(3) subject to section 502(b) for the purpose of enabling the Secretary (through grants, contracts, or otherwise) to provide for developing and expanding the following—

“(A) maternal and infant health home visiting programs in which case management services as defined in subparagraphs (A) and (B) of subsection (b)(4), health education services, and related social support services are provided in the home to pregnant women or families with an infant up to the age one by an appropriate health professional or by a qualified nonprofessional acting under the supervision of a health care professional,

“(B) projects designed to increase the participation of obstetricians and pediatricians under the program under this title and under state plans approved under title XIX,

“(C) integrated maternal and child health service delivery systems (of the type described in section 1136 and using, once developed, the model application form developed under section 6506(a) of the Omnibus Budget Reconciliation Act of 1989),

“(D) maternal and child health centers which (I) provide prenatal, delivery, and postpartum care for pregnant women and preventive and primary care services for infants up to age one and (II) operate under the direction of a not-for-profit hospital,

“(E) maternal and child health projects to serve rural populations, and

“(F) outpatient and community based services programs (including day care services) for children with special health care needs whose medical services are provided primarily through inpatient institutional care.”.

(2) by adding at the end of subsection (b) the following new paragraphs:

“(3) The term ‘care coordination services’ means services to promote the effective and efficient organization and utilization of resources to assure access to necessary comprehensive services for children with special health care needs and their families.

“(4) The term ‘case management services’ means—

“(A) with respect to pregnant women, services to assure access to quality prenatal, delivery, and postpartum care; and

“(B) with respect to infants up to age one, services to assure access to quality preventive and primary care services.”.

(b) CONFORMING AMENDMENT.—Section 505(2)(c)(ii) of such Act (42 U.S.C. 705(2)(C)(ii) is amended by striking “paragraphs (1) through (3) of section 501(a)” and inserting “subparagraphs (A) through (D) of section 501(a)(1)”.

SEC. 6502. ALLOTMENTS TO STATE AND FEDERAL SET-ASIDES.

(a) IN GENERAL.—Section 502 of the Social Security Act (42 U.S.C. 702) is amended—

(1) by amending the first sentence of paragraph (1) of subsection (a) to read as follows: “Of the amounts appropriated under section 501(a) for a fiscal year that are not in excess of 600,000,000, the Secretary shall retain an amount equal to 15 percent for the purpose of carrying out activities described in section 501(a)(2).”;

(2) in subsection (a)(3), by inserting “or subsection (b)” after “this subsection”;

(3) by striking subsection (c), by redesignating subsection (b) as subsection (c), and by inserting after subsection (a) the following new subsection:

“(b)(1)(A) Of the amounts appropriated under section 501(a) for a fiscal year in excess of \$600,000,000 the Secretary shall retain an amount equal to 12¾ percent thereof for the projects described in subparagraphs (A) through (F) of section 501(a)(3).

“(B) Any amount appropriated under section 501(a) for a fiscal year in excess of \$600,000,000 that remains after the Secretary has retained the applicable amount (if any) under subparagraph (A) shall be retained by the Secretary in accordance with subsection (a) and allocated to the States in accordance with subsection (c).

“(2)(A) Of the amounts retained for the purpose of carrying out activities described in section 501(a)(3)(A), (B), (C), (D) and (E), the Sec-

retary shall provide preference to qualified applicants which demonstrate that the activities to be carried out with such amounts shall be in areas with a high infant mortality rate (relative to the average infant mortality rate in the United States or in the State in which the area is located).

“(B) In carrying out activities described in section 501(a)(3)(D), the Secretary shall not provide for developing or expanding a maternal and child health center unless the Secretary has received satisfactory assurances that there will be applied, towards the costs of such development or expansion, non-Federal funds in an amount at least equal to the amount of funds provided under this title toward such development or expansion.”; and

(4) in subsection (c), as redesignated by paragraph (2)—

(A) by striking “\$478,000,000” and inserting “\$600,000,000”, and

(B) by amending paragraph (2) to read as follows:

“(2) Each such State shall be allotted for each fiscal year an amount equal to the sum of—

“(A) the amount of the allotment to the State under this subsection in fiscal year 1983, and

“(B) the State’s proportion (determined under paragraph (1)(B)(ii)) of the amount by which the allotment available under this subsection for all the States for that fiscal year exceeds the amount that was available under this subsection for allotment for all the States for fiscal year 1983.”.

(b) **CONFORMING AMENDMENTS.**—Sections 503(a) and 508(b) of such Act (42 U.S.C. 703(a), 708(b)) are amended by striking “502(b)” each place it appears and inserting “502(c)”.

SEC. 6503. USE OF ALLOTMENT FUNDS AND APPLICATION FOR BLOCK GRANT FUNDS.

(a) **EXPANDING USE OF FUNDS AND LIMITATION ON USE OF FUNDS FOR ADMINISTRATIVE COSTS.**—Section 504 of the Social Security Act (42 U.S.C. 704) is amended—

(1) in subsection (a), by inserting “and including payment of salaries and other related expenses of National Health Service Corps personnel” after “education, and evaluation”, and

(2) by adding at the end the following new subsection:

“(d) Of the amounts paid to a State under section 503 from an allotment for a fiscal year under section 502(c), not more than 10 percent may be used for administering the funds paid under such section.”.

(b) **APPLICATION.**—Section 505 of such Act (42 U.S.C. 705) is amended—

(1) by amending the heading to read as follows:

“APPLICATION FOR BLOCK GRANT FUNDS”;

(2) by inserting “(a)” after “SEC. 505.”;

(3) in the matter before paragraph (1), by inserting “an application (in a standardized form specified by the Secretary) that” after “must prepare and transmit to the Secretary”;

(4) by striking paragraph (1) and redesignating paragraph (2) as paragraph (5) and by inserting before paragraph (5), as redesignated, the following new paragraphs:

“(1) contains a statewide needs assessment (to be conducted every 5 years) that shall identify (consistent with the health status goals and national health objectives referred to in section 501(a)) the need for—

“(A) preventive and primary care services for pregnant women, mothers, and infants up to age one;

“(B) preventive and primary care services for children; and

“(C) services for children with special health care needs (as specified in section 501(a)(1)(D)); and

“(2) includes for each fiscal year—

“(A) a plan for meeting the needs identified by the statewide needs assessment under paragraph (1); and

“(B) a description of how the funds allotted to the State under section 502(c) will be used for the provision and coordination of services to carry out such plan that shall include—

“(i) subject to paragraph (3), a statement of the goals and objectives consistent with the health status goals and national health objectives referred to in section 501(a) for meeting the needs specified in the State plan described in subparagraph (A);

“(ii) an identification of the areas and localities in the state in which services are to be provided and coordinated;

“(iii) an identification of the types of services to be provided and the categories or characteristics of individuals to be served; and

“(iv) information the State will collect in order to prepare reports required under section 506(a);

“(3) except as provided under subsection (b), provides that the State will use—

“(A) at least 30 percent of such payment amounts for preventive and primary care services for children, and

“(B) at least 30 percent of such payment amounts for services for children with special health care needs (as specified in section 501(a)(1)(D)); and

“(4) provides that a State receiving funds for maternal and child health services under this title shall maintain the level of funds being provided solely by such State for maternal and child health programs at a level at least equal to the level that such State provided for such programs in fiscal year 1989.”; and

(5) in paragraph (5), as redesignated by paragraph (4) of this subsection—

(A) by striking “a statement of assurances that represents to the Secretary” and inserting “provides”;

(B) in subparagraph (A), by striking “will provide” and inserting “will establish”;

(C) by amending subparagraph (C)(i) to read as follows:

“(C)(i) special consideration will be given (where appropriate) to the continuation of the funding of special projects in the State previously funded under this title (as in effect before August 31, 1981);”;

(D) in subparagraph (D), by striking “and” at the end;
 (E) by redesignating subparagraph (E) as subparagraph (F) and by inserting after subparagraph (D) the following new subparagraph:

“(E) the State agency (or agencies) administering the State’s program under this title will provide for a toll-free telephone number (and other appropriate methods) for the use of parents to access information about health care providers and practitioners who provide health care services under this title and title XIX and about other relevant health and health-related providers and practitioners;”;
 and

(F) in subparagraph (F) (as redesignated by subparagraph (E))—

(i) by striking “participate” before clause (i),
 (ii) in clause (i), by striking “diagnosis” and inserting “diagnostic”,

(iii) in clause (i), by striking “title XIX” and inserting “section 1905(a)(4)(B) (including the establishment of periodicity and content standards for early and periodic screening, diagnostic, and treatment services)”;

(iv) by inserting “participate” after “(i)”, after “(ii)”, and after “(iii)”,

(v) by striking “and” at the end of clause (ii),

(vi) by striking the period at the end of clause (iii) and inserting “, and”, and

(vii) by adding after clause (iii) the following new clause:

“(iv) provide, directly and through their providers and institutional contractors, for services to identify pregnant women and infants who are eligible for medical assistance under subparagraph (A) or (B) of section 1902(l)(1) and, once identified, to assist them in applying for such assistance; and”; and

(6) by striking the last 2 sentences and inserting the following: “The application shall be developed by, or in consultation with, the State maternal and child health agency and shall be made public within the State in such manner as to facilitate comment from any person (including any Federal or other public agency) during its development and after its transmittal.”;

(7) by adding at the end the following new subsection:

“(b) The Secretary may waive the requirement under subsection (a)(3) that a State’s application for a fiscal year provide for the use of funds for specific activities if for that fiscal year—

“(1) the Secretary determines—

“(A) on the basis of information provided in the State’s most recent annual report submitted under section 506(a)(1), that the State has demonstrated an extraordinary unmet need for one of the activities described in subsection (a)(3), and

“(B) that the granting of the waiver is justified and will assist in carrying out the purposes of this title; and

"(2) the State provides assurances to the Secretary that the State will provide for the use of some amounts paid to it under section 503 for the activities described in subparagraphs (A) and (B), of subsection (a)(3) and specifies the percentages to be substituted in each of such subparagraphs."

(c) CONFORMING AMENDMENTS.—(1) Section 502(c) of such Act (42 U.S.C. 702(c)), as redesignated by section 6502(a)(3) of this subtitle, is amended by striking "a description of intended activities and statement of assurances" and inserting "an application".

(2) Section 504(a) of such Act (42 U.S.C. 704(a)) is amended by striking "its description of intended expenditures and statement of assurances" and insert "its application".

(3) Section 506(a)(1) of such Act (42 U.S.C. 706(a)(1)) is amended by striking "description and statement" and inserting "application".

(4) Sections 502(b), 502(d)(1), 503(c), 504(a), 506(a)(1)(C), and 509(a)(6) of such Act (42 U.S.C. 702(b), 702(d)(1), 703(c), 704(a), 706(a)(1)(C), and 709(a)(6)) are each amended by striking "505" each place it appears and inserting "505(a)".

SEC. 6504. REPORTS.

(a) STATE REPORTS.—Subsection (a) of section 506 of the Social Security Act (42 U.S.C. 706) is amended—

(1) in paragraph (1)—

(A) by inserting after the first sentence the following: "Each such report shall be prepared by, or in consultation with, the State maternal and child health agency.";

(B) by striking "be in such form and contain such information" and inserting "be in such standardized form and contain such information (including information described in paragraph (2))"; and

(C) by striking "and of the progress made toward achieving the purposes of this title, and (C)" and inserting ", (C) to describe the extent to which the State has met the goals and objectives it set forth under section 505(a)(2)(B)(i) and the national health objectives referred to in section 501(a).";

(2) by redesignating paragraph (2) as paragraph (3); and

(3) by inserting after paragraph (1) the following new paragraph:

"(2) Each annual report under paragraph (1) shall include the following information:

"(A)(i) The number of individuals served by the State under this title (by class of individuals).

"(ii) The proportion of each class of such individuals which has health coverage.

"(iii) The types (as defined by the Secretary) of services provided under this title to individuals within each such class.

"(iv) The amounts spent under this title on each type of services, by class of individuals served.

"(B) Information on the status of maternal and child health in the State, including—

"(i) information (by county and by racial and ethnic group) on—

"(I) the rate of infant mortality, and

"(II) the rate of low-birth-weight births;

“(ii) information (on a State-wide basis) on—

“(I) the rate of maternal mortality,

“(II) the rate of neonatal death,

“(III) the rate of perinatal death,

“(IV) the number of children with chronic illness and the type of illness,

“(V) the proportion of infants born with fetal alcohol syndrome,

“(VI) the proportion of infants born with drug dependency,

“(VII) the proportion of women who deliver who do not receive prenatal care during the first trimester of pregnancy, and

“(VIII) the proportion of children, who at their second birthday, have been vaccinated against each of measles, mumps, rubella, polio, diphtheria, tetanus, pertussis, Hib meningitis, and hepatitis B; and

“(iii) information on such other indicators of maternal, infant, and child health care status as the Secretary may specify.

“(C) Information (by racial and ethnic group) on—

“(i) the number of deliveries in the State in the year, and

“(ii) the number of such deliveries to pregnant women who were provided prenatal, delivery, or postpartum care under this title or were entitled to benefits with respect to such deliveries under the State plan under title XIX in the year.

“(D) Information (by racial and ethnic group) on—

“(i) the number of infants under one year of age who were in the State in the year, and

“(ii) the number of such infants who were provided services under this title or were entitled to benefits under the State plan under title XIX at any time during the year.

“(E) Information on the number of—

“(i) obstetricians,

“(ii) family practitioners,

“(iii) certified family nurse practitioners,

“(iv) certified nurse midwives,

“(v) pediatricians, and

“(vi) certified pediatric nurse practitioners,

who were licensed in the State in the year.

For purposes of subparagraph (A), each of the following shall be considered to be a separate class of individuals: pregnant women, infants up to age one, children with special health care needs, other children under age 22, and other individuals.”

(b) SECRETARIAL REPORT.—Paragraph (3) of subsection (a) of such section, as redesignated by subsection (a)(2) of this section, is amended to read as follows:

“(3) The Secretary shall annually transmit to the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate a report that includes—

“(A) a description of each project receiving funding under paragraph (2) or (3) of section 502(a), including the amount of Federal funds provided, the number of individuals served or

trained, as appropriate, under the project, and a summary of any formal evaluation conducted with respect to the project;

“(B) a summary of the information described in paragraph (2)(A) reported by States;

“(C) based on information described in paragraph (2)(B) supplied by the States under paragraph (1), a compilation of the following measures of maternal and child health in the United States and in each State:

“(i) Information on—

“(I) the rate of infant mortality, and

“(II) the rate of low-birth-weight births.

Information under this clause shall also be compiled by racial and ethnic group.

“(ii) Information on—

“(I) the rate of maternal mortality, and

“(II) the rate of neonatal death,

“(III) the rate of perinatal death,

“(IV) the proportion of infants born with fetal alcohol syndrome,

“(V) the proportion of infants born with drug dependency,

“(VI) the proportion of women who deliver who do not receive prenatal care during the first trimester of pregnancy, and

“(VII) the proportion of children, who at their second birthday, have been vaccinated against each of measles, mumps, rubella, polio, diphtheria, tetanus, pertussis, Hib meningitis, and hepatitis B.

“(iii) Information on such other indicators of maternal, infant, and child health care status as the Secretary has specified under paragraph (2)(B)(iii).

“(iv) Information on (by racial and ethnic group)—

“(I) the number of deliveries in the State in the year, and

“(II) the number of such deliveries to pregnant women who were provided prenatal, delivery, or postpartum care under this title or were entitled to benefits with respect to such deliveries under the State plan under title XIX in the year;

“(D) based on information described in subparagraphs (C), (D), and (E) of paragraph (2) supplied by the States under paragraph (1), a compilation of the following information in the United States and in each State:

“(i) Information on—

“(I) the number of deliveries in the year, and

“(II) the number of such deliveries to pregnant women who were provided prenatal, delivery, or postpartum care under this title or were entitled to benefits with respect to such deliveries under a State plan under title XIX in the year.

Information under this clause shall also be compiled by racial and ethnic group.

“(ii) Information on—

"(I) the number of infants under one year of age in the year, and

"(II) the number of such infants who were provided services under this title or were entitled to benefits under a State plan under title XIX at any time during the year.

Information under this clause shall also be compiled by racial and ethnic group.

"(iii) Information on the number of—

"(I) obstetricians,

"(II) family practitioners,

"(III) certified family nurse practitioners,

"(IV) certified nurse midwives,

"(V) pediatricians, and

"(VI) certified pediatric nurse practitioners,

who were licensed in a State in the year; and

"(E) an assessment of the progress being made to meet the health status goals and national health objectives referred to in section 501(a)."

SEC. 6505. FEDERAL ADMINISTRATION AND ASSISTANCE.

Section 509(a) of such Act (42 U.S.C. 709(a)) is amended—

(1) in paragraph (4) by inserting before the semicolon at the end the following: "and in developing consistent and accurate data collection mechanisms in order to report the information required under section 506(a)(2)";

(2) in paragraph (5) by striking "and" at the end thereof;

(3) in paragraph (6) by striking the period and inserting in lieu thereof "; and" and

(4) by adding at the end thereof the following new paragraphs:

"(7) assisting States in the development of care coordination services (as defined in section 501(b)(3)); and

"(8) developing and making available to the State agency (or agencies) administering the State's program under this title a national directory listing by State the toll-free number described in section 505(a)(5)(E)."

SEC. 6506. DEVELOPMENT OF MODEL APPLICATIONS.

(a) FOR MATERNAL AND CHILD ASSISTANCE PROGRAMS.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall develop, by not later than one year after the date of the enactment of this Act and in consultation with the Secretary of Agriculture, a model application form for use in applying, simultaneously, for assistance for a pregnant woman or a child less than 6 years of age under maternal and child assistance programs (as defined in paragraph (3)). In developing such form, the Secretary is not authorized to change any requirement with respect to eligibility under any maternal and child assistance program.

(2) DISSEMINATION OF MODEL FORM.—The Secretary shall provide for publication in the Federal Register of the model application form developed under paragraph (1) and shall send a copy of such form to each State agency responsible for administering a maternal and child assistance program.

(3) **MATERNAL AND CHILD ASSISTANCE PROGRAM DEFINED.**—In this subsection, the term “maternal and child assistance program” means any of the following programs:

(A) The maternal and child health block grant program under title V of the Social Security Act.

(B) The medicaid program under title XIX of the Social Security Act.

(C) The migrant and community health centers programs under sections 329 and 330 of the Public Health Service Act.

(D) The grant program for the homeless under section 340 of the Public Health Service Act.

(E) The “WIC” program under section 17 of the Child Nutrition Act of 1966.

(F) The head start program under the Head Start Act.

(b) **FOR MEDICAID PROGRAM.**—

(1) **IN GENERAL.**—The Secretary of Health and Human Services shall, by not later than 1 year after the date of the enactment of this Act, develop a model application form for use in applying for benefits under title XIX of the Social Security Act for individuals who are not receiving cash assistance under part A of title IV of the Social Security Act, and who are not institutionalized. In developing such model application form, the Secretary is not authorized to require that such form be adopted by States as part of their State medicaid plan.

(2) **DISSEMINATION OF MODEL FORM.**—The Secretary shall provide for publication in the Federal Register of the model application form developed under paragraph (1), and shall send a copy of such form to each State agency responsible for administering the State medicaid plan.

SEC. 6507. RESEARCH ON INFANT MORTALITY AND MEDICAID SERVICES.

The Secretary of Health and Human Services shall develop a national data system for linking, for any infant up to age one—

(1) the infant’s birth record,

(2) any death record for the infant, and

(3) information on any claims submitted under title XIX of the Social Security Act for health care furnished to the infant or with respect to the birth of the infant.

SEC. 6508. DEMONSTRATION PROJECT ON HEALTH INSURANCE FOR MEDICALLY UNINSURABLE CHILDREN.

(a) **IN GENERAL.**—The Secretary of Health and Human Services (in this section referred to as the “Secretary”) may conduct not more than 4 demonstration projects to provide health insurance coverage (as defined by the Secretary) through an eligible plan (as defined in subsection (b)) to medically uninsurable children (as defined by the Secretary) under the age of 19.

(b) **ELIGIBILITY.**—In this section, the term “eligible plan” means—

(1) a school-based plan;

(2) a plan operated under the direction of not-for-profit entities offering health insurance; and

(3) a plan operated by not-for-profit hospitals.

(c) **REQUIREMENTS.**—A demonstration project conducted under subsection (a) may only be conducted under an agreement between the Secretary and an eligible plan which provides that—

(1) health insurance coverage will be made available under the project for at least 2 years, and, if the eligible plan fails to provide such coverage during such period, the Secretary will guarantee the provision of such coverage;

(2) non-Federal funds will be made available to fund the project at a level not less than—

(A) 50 percent in the first year of such agreement,

(B) 65 percent in the second year of such agreement, and

(C) 80 percent in the third or subsequent year of such agreement;

(3) the plan may not—

(A) restrict health insurance coverage on the basis of a child's medical condition, or

(B) impose waiting periods or exclusions for preexisting conditions;

(4) any premium imposed under the project shall be disclosed in advance of enrollment and shall be varied by the income of individuals; and

(5) that with respect to a plan which at the time of entering into such agreement is conducting a project similar to the one described in this paragraph that such plan must maintain its current level of non-Federal funding at such current level unless such level is less than the applicable level described in paragraph (2).

(d) **APPLICATION.**—No funds may be made available by the Secretary under this section unless an application therefor has been submitted to, and approved by, the Secretary. Such application shall be in such form, be submitted in such manner, and contain and be accompanied by such information as the Secretary may specify. No such application may be approved unless it contains assurances that the applicant will use the funds provided only for the purposes specified in the approved application and will establish such fiscal control and fund accounting procedures as may be necessary to assure proper disbursement and accounting of Federal funds paid to the applicant under this section.

(e) **EVALUATION AND REPORT.**—

(1) **EVALUATION.**—The Secretary shall provide for an evaluation of the effects of the demonstration projects conducted under subsection (a) on—

(A) access to health services by previously medically uninsurable children,

(B) the availability of insurance coverage to participating medically uninsurable children,

(C) the demographic characteristics and health status of participating medically uninsurable children and their families, and

(D) out-of-pocket health care costs for such families.

(2) **REPORT.**—The Secretary shall submit a report on the demonstration projects conducted under subsection (a) to the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate, and shall include

in such report a summary of the evaluation described in paragraph (1).

(f) **AUTHORIZATION OF APPROPRIATIONS.**—There are authorized to be appropriated to carry out this section \$5,000,000, for each of fiscal years 1991, 1992, and 1993.

SEC. 6509. MATERNAL AND CHILD HEALTH HANDBOOK.

(a) **IN GENERAL.**—

(1) **DEVELOPMENT.**—The Secretary shall develop a maternal and child health handbook in consultation with the National Commission to Prevent Infant Mortality and public and private organizations interested in the health and welfare of mothers and children.

(2) **FIELD TESTING AND EVALUATION.**—The Secretary shall complete publication of the handbook for field testing by July 1, 1990, and shall complete field testing and evaluation by June 1, 1991.

(3) **AVAILABILITY AND DISTRIBUTION.**—The Secretary shall make the handbook available to pregnant women and families with young children, and shall provide copies of the handbook to maternal and child health programs (including maternal and child health clinics supported through either title V or title XIX of the Social Security Act, community and migrant health centers under sections 329 and 330 of the Public Health Service Act, the grant program for the homeless under section 340 of the Public Health Service Act, the “WIC” program under section 17 of the Child Nutrition Act of 1966, and the head start program under the Head Start Act) that serve high-risk women. The Secretary shall coordinate the distribution of the handbook with State maternal and child health departments, State and local public health clinics, private providers of obstetric and pediatric care, and community groups where applicable. The Secretary shall make efforts to involve private entities in the distribution of the handbook under this paragraph.

(b) **AUTHORIZATION OF APPROPRIATIONS.**—There are authorized to be appropriated \$1,000,000 for each of fiscal years 1991, 1992, and 1993, for carrying out the purposes of this section.

SEC. 6510. EFFECTIVE DATES.

(a) **IN GENERAL.**—Except as provided in subsection (b), the amendments made by this subtitle shall apply to appropriations for fiscal years beginning with fiscal year 1990.

(b) **APPLICATION AND REPORT.**—The amendments made—

(1) by subsections (b) and (c) of section 6503 shall apply to payments for allotments for fiscal years beginning with fiscal year 1991, and

(2) by section 6504 shall apply to annual reports for fiscal years beginning with fiscal year 1991.

Subtitle D—Vaccine Compensation Technicals

SEC. 6601. VACCINE INJURY COMPENSATION TECHNICALS.

(a) **REFERENCE.**—Whenever in this section an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Public Health Service Act.

limitation with respect to any preexisting condition of such beneficiary”.

(B) EFFECTIVE DATE.—*The amendments made by subparagraph (A) shall apply to—*

(i) qualifying events occurring after December 31, 1989, and

(ii) in the case of qualified beneficiaries who elected continuation coverage after December 31, 1988, the period for which the required premium was paid (or was attempted to be paid but was rejected as such).

(3) PARAGRAPH (3).—

(A) IN GENERAL.—*Section 2202(3) of the Public Health Service Act (42 U.S.C. 300bb-2(3)) is amended by amending the matter after and below subparagraph (B) to read as follows:*

“In no event may the plan require the payment of any premium before the day which is 45 days after the day on which the qualified beneficiary made the initial election for continuation coverage.”.

(B) EFFECTIVE DATE.—*The amendment made by subparagraph (A) shall apply to plan years beginning after December 31, 1989.*

(c) SECTION 2208.—

(1) PARAGRAPH (2).—*Section 2208(2) of the Public Health Service Act (42 U.S.C. 300bb-8(2)) is amended by striking “the individual’s employment or previous employment with an employer” and inserting “the performance of services by the individual for 1 or more persons maintaining the plan (including as an employee defined in section 401(c)(1) of the Internal Revenue Code of 1986)”.*

(2) EFFECTIVE DATE.—*The amendment made by paragraph (1) shall apply to plan years beginning after December 31, 1989.*

Subtitle F—Technical and Miscellaneous Provisions Relating to Nursing Home Reform

SEC. 6901. MEDICARE AND MEDICAID TECHNICAL CORRECTIONS RELATING TO NURSING HOME REFORM.

(a) MORATORIUM ON IMPLEMENTATION OF FEBRUARY 2, 1989 REGULATION.—*The regulations promulgated by the Secretary of Health and Human Services on February 2, 1989 (54 Federal Register 5315 et seq., relating to requirements for long-term care facilities) shall not be effective before October 1, 1990, insofar as such regulations apply to skilled nursing facilities and intermediate care facilities under title XVIII or XIX of the Social Security Act.*

(b) NURSE AIDE TRAINING.—

(1) DELAY IN REQUIREMENT.—*Sections 1819(b)(5) and 1919(b)(5) of the Social Security Act (42 U.S.C. 1395i-3(b)(5), 1396r(b)(5)) are each amended—*

(A) in subparagraph (A), by striking “January 1, 1990” and inserting “October 1, 1990”, and

(B) in subparagraph (B), by striking “July 1, 1989” and “January 1, 1990” and inserting “January 1, 1990” and “October 1, 1990”, respectively.

(2) **PUBLICATION OF PROPOSED REGULATIONS.**—The Secretary of Health and Human Services shall issue proposed regulations to establish the requirements described in sections 1819(f)(2) and 1919(f)(2) of the Social Security Act by not later than 90 days after the date of the enactment of this Act.

(3) **REQUIREMENTS FOR TRAINING AND EVALUATION PROGRAMS.**—Sections 1819(f)(2)(A) and 1919(f)(2)(A) of the Social Security Act (42 U.S.C. 1395i-3(f)(2)(A), 1396r(f)(2)(A)) are each amended—

(A) in clause (i)(I), by inserting “care of cognitively impaired residents,” after “social service needs,”;

(B) in clause (ii), by striking “cognitive, behavioral and social care” and by inserting “recognition of mental health and social service needs, care of cognitively impaired residents”;

(C) by striking the period at the end of clause (iii) and inserting “; and”; and

(D) by adding at the end the following new clause:

“(iv) requirements, under both such programs, that—

“(I) provide procedures for determining competency that permit a nurse aide, at the nurse aide’s option, to establish competency through procedures or methods other than the passing of a written examination and to have the competency evaluation conducted at the nursing facility at which the aide is (or will be) employed (unless the facility is described in subparagraph (B)(iii)(I)), and

“(II) prohibit the imposition on a nurse aide of any charges (including any charges for textbooks and other required course materials and any charges for the competency evaluation) for either such program.”.

(4) **DELAY AND TRANSITION IN 75-HOUR TRAINING PROGRAM REQUIREMENT.**—

(A) Sections 1819(f)(2)(B)(ii) and 1919(f)(2)(B)(ii) of such Act (42 U.S.C. 1395i-3(f)(2)(B)(ii), 1396r(f)(2)(B)(ii)) are each amended by striking “January 1, 1989” and inserting “July 1, 1989”.

(B) A nurse aide shall be considered to satisfy the requirement of sections 1819(b)(5)(A) and 1919(b)(5)(A) of the Social Security Act (of having completed a training and competency evaluation program approved by a State under section 1819(e)(1)(A) or 1919(e)(1)(A) of such Act), if such aide would have satisfied such requirement as of July 1, 1989, if a number of hours (not less than 60 hours) were substituted for “75 hours” in sections 1819(f)(2) and 1919(f)(2) of such Act, respectively, and if such aide had received, before July 1, 1989, at least the difference in the number of such hours in supervised practical nurse aide training or in regular in-service nurse aide education.

(C) A nurse aide shall be considered to satisfy the requirement of sections 1819(b)(5)(A) and 1919(b)(5)(A) of the Social Security Act (of having completed a training and competency evaluation program approved by a State under section 1819(e)(1)(A) or 1919(e)(1)(A) of such Act), if such aide was found competent (whether or not by the State), before July 1, 1989, after the completion of a course of nurse aide training of at least 100 hours duration.

(D) With respect to the nurse aide competency evaluation requirements described in sections 1819(b)(5)(A) and 1919(b)(5)(A) of the Social Security Act, a State may waive such requirements with respect to an individual who can demonstrate to the satisfaction of the State that such individual has served as a nurse aide at one or more facilities of the same employer in the State for at least 24 consecutive months before the date of the enactment of this Act.

(5) CLARIFICATION OF TEMPORARY ENHANCED FEDERAL FINANCIAL PARTICIPATION FOR NURSE AIDE TRAINING BY NURSING FACILITIES.—

(A) *IN GENERAL.*—Section 1903(a)(2)(B) of such Act (42 U.S.C. 1396b(a)(2)(B)) is amended—

(i) by inserting “(including the costs for nurse aides to complete such competency evaluation programs)” after “1919(e)(1)”, and

(ii) by inserting “(or, for calendar quarters beginning on or after July 1, 1988, and before July 1, 1990, the lesser of 90 percent or the Federal medical assistance percentage plus 25 percentage points)” after “50 percent”.

(B) *NO ALLOCATION OF COSTS BEFORE OCTOBER 1, 1990.*—In making payments under section 1903(a)(2)(B) of the Social Security Act for amounts expended for nurse aide training and competency evaluation programs, and competency evaluation programs, described in section 1919(e)(1) of such Act, in the case of activities conducted before October 1, 1990, the Secretary of Health and Human Services shall not take into account, or allocate amounts on the basis of, the proportion of residents of nursing facilities that is entitled to benefits under title XVIII or XIX of such Act.

(6) EFFECTIVE DATES.—

(A) *IN GENERAL.*—Except as provided in subparagraph (B), the amendments made by this subsection shall take effect as if they were included in the enactment of the Omnibus Budget Reconciliation Act of 1987.

(B) *EXCEPTION.*—The amendments made by paragraph (3) shall apply to nurse aide training and competency evaluation programs, and nurse aide competency evaluation programs, offered on or after the end of the 90-day period beginning on the date of the enactment of this Act, but shall not affect competency evaluations conducted under programs offered before the end of such period.

(C) *PUBLICATION OF PROPOSED REGULATIONS RESPECTING PREADMISSION SCREENING AND ANNUAL RESIDENT REVIEW.*—The Secretary of Health and Human Services shall issue proposed regulations to

establish the criteria described in section 1919(f)(8)(A) of the Social Security Act by not later than 90 days after the date of the enactment of this Act.

(d) OTHER AMENDMENTS.—

(1) CLARIFICATION OF APPLICABILITY OF ENFORCEMENT RULES TO DUALY-CERTIFIED FACILITIES.—Section 1919(h)(8) of such Act (42 U.S.C. 1396r(h)(8)) is amended by adding at the end the following: “The provisions of this subsection shall apply to a nursing facility (or portion thereof) notwithstanding that the facility (or portion thereof) also is a skilled nursing facility for purposes of title XVIII.”

(2) CLARIFICATION OF FEDERAL MATCHING RATE FOR SURVEY AND CERTIFICATION ACTIVITIES.—During the period before October 1, 1990, the Federal percentage matching payment rate under section 1903(a) of the Social Security Act for so much of the sums expended under a State plan under title XIX of such Act as are attributable to compensation or training of personnel responsible for inspecting public or private skilled nursing or intermediate care facilities to individuals receiving medical assistance to determine compliance with health or safety standards shall be 75 percent.

(3) MEDICARE WAIVER AUTHORITY FOR CERTAIN DEMONSTRATION PROJECTS.—(A) The Secretary of Health and Human Services may waive the survey and certification requirements of sections 1819(g) and 1864(a) of the Social Security Act to the extent the Secretary determines is required to carry out a demonstration project in New York (relating to testing an approved alternative survey and certification process), which has been approved as of the date of the enactment of this Act. Such waiver shall apply only during the period beginning on November 1, 1988, and ending on October 31, 1991.

(B) The Secretary also may waive the survey and certification requirements described in subparagraph (A) to the extent the Secretary determines is required to carry out a pilot demonstration project in Wisconsin (relating to testing an approved alternative survey and certification process). Such waiver shall apply only during the one-year period beginning on the date of implementation of the project.

(4) MISCELLANEOUS TECHNICAL CORRECTIONS.—Sections 1819 and 1919 of such Act are each further amended—

(A) in subsection (c)(1)(A)(ii)(II), by striking the closing parenthesis after “Secretary” and inserting a closing parenthesis after “obtained”,

(B) in subsection (c)(1)(A)(v)(I), by striking “accommodations” and inserting “accommodation”,

(C) in subsection (f)(2)(A)(i), by striking “, content of the curriculum” and inserting “and content of the curriculum”, and

(D) in subsection (h)(2)(C) (of section 1819) and in subsection (h)(3)(D) (of section 1919), by inserting “after the effective date of the findings” after “6 months”.

(5) ADDITIONAL MISCELLANEOUS TECHNICAL CORRECTION.—Section 1910 of such Act (42 U.S.C. 1396i) is amended—

(A) by inserting “AND INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED” after “RURAL HEALTH CLINICS”,

(B) in subsection (b)(1), by striking “skilled nursing or intermediate care facility” and inserting “intermediate care facility for the mentally retarded”,

(C) in subsection (b)(1), as amended by section 411(l)(6)(F) of the Medicare Catastrophic Coverage Act of 1988, by striking “1902(a)(28) or section 1919 or section 1905(c) and inserting “1902(a)(31) or section 1905(d)”, and

(D) in subsections (b)(1) and (b)(2), by striking “skilled nursing facility or intermediate care facility” each place it appears and inserting “intermediate care facility for the mentally retarded”.

(6) **EFFECTIVE DATE.**—

(A) **IN GENERAL.**—Except as provided in subparagraph (B), the amendments made by this subsection shall take effect as if they were included in the enactment of the Omnibus Budget Reconciliation Act of 1987.

(B) **EXCEPTION.**—The amendment made by paragraph (2) shall take effect on the date of the enactment of this Act.

Subtitle G—Public Health Service Act

SEC. 6911. ESTABLISHMENT OF AGENCY FOR HEALTH CARE POLICY AND RESEARCH.

For amendments establishing the Agency for Health Care Policy and Research and creating a new title IX in the Public Health Service Act, see section 6103 of this Act.

TITLE VII—REVENUE MEASURES

SEC. 7001. SHORT TITLE; ETC.

(a) **SHORT TITLE.**—This title may be cited as the “Revenue Reconciliation Act of 1989”.

(b) **AMENDMENT OF 1986 CODE.**—Except as otherwise expressly provided, whenever in this title an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Internal Revenue Code of 1986.

(c) TABLE OF CONTENTS.—

TITLE VII—REVENUE MEASURES

Sec. 7001. Short title; etc.

Subtitle A—Extension of Expiring Tax Provisions

Sec. 7101. Employer-provided educational assistance.

Sec. 7102. Employer-provided group legal services.

Sec. 7103. Extension and modification of targeted jobs credit.

Sec. 7104. Extension of qualified mortgage bonds.

Sec. 7105. Extension of qualified small issue bonds.

Sec. 7106. Extension of energy investment credit for solar, geothermal, and ocean thermal property.

Sec. 7107. Extension of special rules for health insurance costs of self-employed individuals.

Sec. 7108. Extension and modification of low-income housing credit.

“(i) The preceding provisions of this section shall not apply with respect to amendments made to this title in provisions enacted after the date of the enactment of the Tax Reform Act of 1986.”

(B) The amendment made by subparagraph (A) shall take effect as if originally included in the Reform Act.

(i) EFFECTIVE DATE.—Except as otherwise provided in this section, any amendment made by this section shall take effect as if originally included in the provision of the Employee Retirement Income Security Act of 1974 to which such amendment relates.

TITLE VIII—HUMAN RESOURCE AND INCOME SECURITY PROVISIONS

SEC. 8000. TABLE OF CONTENTS; AMENDMENT OF SOCIAL SECURITY ACT.

(a) TABLE OF CONTENTS.—

Sec. 8000. Table of contents; amendment of Social Security Act.

Sec. 8001. Extension of authority to transfer foster care funds to child welfare services.

Sec. 8002. Extension of independent living initiatives program.

Sec. 8003. Permanent extension of medicaid eligibility extension due to collection of child or spousal support.

Sec. 8004. New AFDC quality control system.

Sec. 8005. Emergency assistance and AFDC special needs.

Sec. 8006. Increase in reimbursement for foster and adoptive parent training.

Sec. 8007. Case plans to include health and education records and to be reviewed and updated at the time of each placement.

Sec. 8008. Establishment and conduct of outreach program for children.

Sec. 8009. Eligibility for benefits of children of Armed Forces personnel residing overseas.

Sec. 8010. Rule for deeming to children the income and resources of their parents waived for certain disabled children.

Sec. 8011. Exclusion from income of domestic commercial transportation tickets received as gifts.

Sec. 8012. Reduction in time during which income and resources of separated couples must be treated as jointly available.

Sec. 8013. Exclusion of accrued income with respect to purchase of certain burial spaces.

Sec. 8014. Exclusion from resources of all income-producing property.

Sec. 8015. Demonstration of effectiveness of Minnesota Family Investment Plan.

Sec. 8016. Increase in funding for title XX social services block grant.

(b) AMENDMENT OF SOCIAL SECURITY ACT.—Except as otherwise expressly provided, whenever in this title an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Social Security Act.

SEC. 8001. EXTENSION OF AUTHORITY TO TRANSFER FOSTER CARE FUNDS TO CHILD WELFARE SERVICES.

(a) 3-YEAR EXTENSION.—Subsections (b)(1), (b)(2)(B), (b)(4)(B), (b)(5)(A), (b)(5)(A)(ii), (c)(1), and (c)(2) of section 474 (42 U.S.C. 674) are each amended by striking “1989” and inserting “1992”

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall take effect on October 1, 1989.

SEC. 8002. EXTENSION OF INDEPENDENT LIVING INITIATIVES PROGRAM.

(a) PROGRAM EXTENDED FOR 3 YEARS.—Section 477 (42 U.S.C. 677) is amended—

(1) in each of subsections (a)(1) and (e)(1), by striking “, 1988, and 1989” and inserting “through 1992”; and

(2) in subsection (c), by striking “the fiscal year 1988 or 1989” and inserting “any of the fiscal years 1988 through 1992”.

(b) **ENTITLEMENT INCREASED.**—Section 477(e)(1) (42 U.S.C. 677(e)(1)) is amended—

(1) by inserting “(A)” after “(1)”; and

(2) by striking “The amount” and inserting “The basic amount”;

(3) by striking “and 1989” and inserting “1989, 1990, 1991, and 1992”;

(4) by striking “\$45,000,000” and inserting “the basic ceiling for such fiscal year”; and

(5) by adding after and below such provision the following:

“(B) The maximum additional amount to which a State shall be entitled under section 474(a)(4) for fiscal years 1991 and 1992 shall be an amount which bears the same ratio to the additional ceiling for such fiscal year as the basic amount of such State bears to \$45,000,000.”; and

“(C) As used in this section:

“(i) The term ‘basic ceiling’ means—

“(I) for fiscal year 1990, \$50,000,000; and

“(II) for each fiscal year other than fiscal year 1990, \$45,000,000.

“(ii) The term ‘additional ceiling’ means—

“(I) for fiscal year 1991, \$15,000,000; and

“(II) for fiscal year 1992, \$25,000,000.”.

(c) **MATCHING PAYMENTS TO STATES.**—Section 474(a)(4) (42 U.S.C. 674(a)(4)) is amended to read as follows:

“(4) an amount equal to the sum of—

“(A) so much of the amounts expended by such State to carry out programs under section 477 as do not exceed the basic amount for such State determined under section 477(e)(1); and

“(B) the lesser of—

“(i) one-half of any additional amounts expended by such State for such programs; or

“(ii) the maximum additional amount for such State under such section 477(e)(1).”.

(d) **STUDY BY THE SECRETARY OF HHS; REPORT.**—

(1) **STUDY.**—The Secretary of Health and Human Services shall study the programs authorized under section 477 of the Social Security Act for the purposes of evaluating the effectiveness of the programs. The study shall include a comparison of outcomes of children who participated in the programs and a comparable group of children who did not participate in the programs.

(2) **REPORT.**—Upon completion of the study, the Secretary shall issue a report to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives.

(e) **EFFECTIVE DATE.**—The amendments made by subsections (a), (b), and (c) shall take effect October 1, 1989.

SEC. 8003. PERMANENT EXTENSION OF MEDICAID ELIGIBILITY EXTENSION DUE TO COLLECTION OF CHILD OR SPOUSAL SUPPORT.

(a) **ELIMINATION OF SUNSET ON APPLICABILITY OF MEDICAID ELIGIBILITY EXTENSION.**—Section 20(b) of the Child Support Enforcement Amendments of 1984 (Public Law 98-378) is amended by striking “and before October 1, 1989”.

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall take effect on October 1, 1989.

SEC. 8004. NEW AFDC QUALITY CONTROL SYSTEM.

(a) **IN GENERAL.**—Part A of title IV (42 U.S.C. 601 et seq.) is amended by inserting after section 407 the following:

“SEC. 408. AFDC QUALITY CONTROL SYSTEM.

“(a) **IN GENERAL.**—In order to improve the accuracy of payments of aid to families with dependent children, the Secretary shall establish and operate a quality control system under which the Secretary shall determine, with respect to each State, the amount (if any) of the disallowance required to be repaid to the Secretary due to erroneous payments made by the State in carrying out the State plan approved under this part.

“(b) **REVIEW OF CASES.**—

“(1) **STATE REVIEW.**—

“(A) **IN GENERAL.**—Each State with a plan approved under this part shall for each fiscal year, in accordance with the time schedule and methodology prescribed in regulations issued under paragraphs (1) and (2) of subsection (h)—

“(i) review a sample of cases in the State with respect to which a payment has been made under such plan during the fiscal year; and

“(ii) determine the level of erroneous payments for the State for the fiscal year.

“(B) **EFFECTS OF FAILURE TO COMPLETE REVIEW IN A TIMELY MANNER.**—

“(i) **SECRETARY CONDUCTS REVIEW.**—If a State fails to conduct and complete, on a timely basis, a review required by subparagraph (A), or otherwise fails to cooperate with the Secretary in implementing this subsection, the Secretary, directly or through contractual or such other arrangements as the Secretary may find appropriate, shall conduct the review and establish the error rate for the State for the fiscal year on the basis of the best data reasonably available to the Secretary, in accordance with the statistical methods that would apply if the review were conducted by the State.

“(ii) **STATE INCURS COSTS OF REVIEW.**—The amount that would otherwise be payable under this part to a State for which the Secretary conducts a review under clause (i) shall be reduced by the costs incurred by the Secretary in conducting the review.

“(2) **REVIEW BY THE SECRETARY.**—The Secretary shall review a subsample of the cases reviewed by the State, or by the Secretary with respect to the State, under paragraph (1).

"(3) NOTIFICATION OF DIFFERENCE CASES.—Upon completion of the review under paragraph (2), the Secretary shall notify the State of any case in the subsample which the Secretary finds involves erroneous payments, and which the State's review determined to be correct (in this section referred to as a 'difference case')."

"(4) ESTABLISHMENT OF QUALITY CONTROL REVIEW PANEL.—The Secretary shall by regulation establish a Quality Control Review Panel to review difference cases."

"(5) RESOLUTION OF DIFFERENCE CASES.—"

"(A) IN GENERAL.—The State may seek review by the Panel of any difference case, within the time period prescribed in regulations issued under subsection (h)(3)."

"(B) PROCEDURAL RULES.—The State and the Secretary may submit such documentation to the Panel as the State or the Secretary finds appropriate to substantiate its position. The findings of the Panel shall be made on the record, within the time period prescribed in regulations issued under subsection (h)(4)."

"(C) STATUS OF DECISIONS OF THE QUALITY CONTROL REVIEW PANEL.—The decisions of the Panel shall constitute the decisions of the Secretary for purposes of establishing the State's error rate for the fiscal year."

"(D) APPEALABILITY OF DECISIONS OF THE QUALITY CONTROL REVIEW PANEL.—The decisions of the Panel shall not be appealable, except as provided in subsection (k)."

"(c) IDENTIFICATION OF ERRONEOUS PAYMENTS.—"

"(1) APPLY PROVISIONS OF STATE PLAN.—Except as provided in paragraph (2), in determining whether a payment is an erroneous payment, the State and the Secretary shall apply all relevant provisions of the State plan approved under this part."

"(2) TREATMENT OF PROVISIONS OF STATE PLAN THAT ARE INCONSISTENT WITH FEDERAL LAW.—"

"(A) IN GENERAL.—If a provision of a State plan approved under this part is inconsistent with a provision of Federal law or regulations, and the Secretary has notified the State of the inconsistency, the provision of Federal law or regulations shall control."

"(B) EXCEPTION.—Subparagraph (A) shall not apply with respect to a payment of the State if—"

"(i) it is necessary for the State to enact a law in order to remove an inconsistency described in subparagraph (A), the Secretary has advised the State that the State will be allowed a reasonable period in which to enact such a law, and the payment was made during such period; or"

"(ii) the State agency made the payment in compliance with a court order."

"(3) CERTAIN PAYMENTS NOT CONSIDERED ERRONEOUS.—For purposes of this section, a payment by a State shall not be considered an erroneous payment if the payment is in error solely by reason of—"

"(A) the State's failure to implement properly changes in Federal statute within 6 months after the effective date of"

such changes or, if later, 6 months after the issuance of final regulations (including regulations in interim final form) if such regulations are reasonably necessary to construe or apply the Federal statutory change;

“(B) the State’s reliance upon and correct use of erroneous information provided by the Secretary about matters of fact;

“(C) the State’s reliance upon and correct use of written statements of Federal policy provided to the State by the Secretary;

“(D) the occurrence of an event in the State that—

“(i) results in the declaration by the President or the Governor of the State of a state of emergency or major disaster; and

“(ii) directly affects the State agency’s ability to make correct payments under the State plan approved under this part; or

“(E) the failure of a family to submit monthly reports to the State pursuant to section 402(a)(14), if the failure did not affect the amount of the payment.

“(4) **CERTAIN PAYMENTS CONSIDERED ERRONEOUS.**—Notwithstanding any other provision of this section, a payment shall be considered an erroneous payment if the payment is made to a family—

“(A) which has failed without good cause to assign support rights as required by section 402(a)(26); or

“(B) any member of which is a recipient of aid under a State plan approved under this part and does not have a social security account number (unless an application for a social security account number for the family member has been filed within 30 days after the date of application for such aid).

“(d) **DETERMINATION OF ERROR RATES.**—

“(1) **IN GENERAL.**—The Secretary shall, in accordance with this subsection, determine an error rate for each State for the fiscal year involved, based on the reviews under paragraphs (1) and (2) of subsection (b) and the decisions of the Quality Control Review Panel under subsection (b)(5).

“(2) **ERROR RATE FORMULA.**—Except as provided in paragraph (3), the State’s error rate for a fiscal year is—

“(A) the ratio of—

“(i) the erroneous payments of the State for the fiscal year; to

“(ii) the total payments of aid under the State plan approved under this part for the fiscal year; reduced by

“(B) the amount by which—

“(i) the national average underpayment rate for the fiscal year; exceeds

“(ii) the underpayment rate of the State for the fiscal year.

“(3) **APPLICATION OF REDUCTION TO SUBSEQUENT FISCAL YEAR.**—At the request of a State, the Secretary shall apply the reduction described in paragraph (2)(B) in determining the State’s error rate for either of the 2 following fiscal years in-

stead of in determining the State's error rate for the fiscal year to which the reduction would otherwise apply.

"(e) **NOTIFICATION TO STATES OF ERROR RATES.**—The Secretary shall notify each State of the error rate of the State determined under subsection (d), within the time period prescribed in regulations issued under subsection (h)(5).

"(f) **IMPOSITION OF DISALLOWANCES.**—If a State's error rate for a fiscal year exceeds the national average error rate for the fiscal year, the Secretary shall impose a disallowance on the State for the fiscal year in an amount equal to—

"(1) the product of—

"(A) the State's total payments of aid to families with dependent children for the fiscal year;

"(B) the Federal medical assistance percentage applicable to the State for purposes of section 1118;

"(C) the lesser of—

"(i) the ratio of—

"(I) the amount by which the State's error rate for the fiscal year exceeds the national average error rate for the fiscal year; to

"(II) the national average error rate for the fiscal year; or

"(ii) 1; and

"(D) the amount by which the State's error rate for the fiscal year exceeds the national average error rate for the fiscal year;

reduced by

"(2) the product of—

"(A) the ratio of—

"(i) the amount by which the State's error rate for the fiscal year exceeds the national average error rate for the fiscal year; and

"(ii) the State's error rate for the fiscal year;

"(B) the overpayments recovered by the State in the fiscal year; and

"(C) the Federal medical assistance percentage applicable to the State for purposes of section 1118;

and further reduced by

"(3) the product of—

"(A) the calculation described in paragraphs (1) and (2); and

"(B) the percentage by which—

"(i) the State's rate of child support collections for the fiscal year; exceeds

"(ii) the lesser of—

"(I) the national average rate of child support collections for the fiscal year; or

"(II) the average of the State's child support collection rates for each of the 3 fiscal years preceding the fiscal year.

"(g) **NOTIFICATION TO STATES OF AMOUNTS OF DISALLOWANCES.**—The Secretary shall notify each State on which the Secretary imposes a disallowance the amount of the disallowance, within the time period prescribed in regulations issued under subsection (h)(6).

“(h) REGULATIONS.—The Secretary, after consultation with the chief executives of the States, shall by regulation prescribe—

“(1) the periods within which—

“(A) the reviews required by paragraphs (1) and (2) of subsection (b) are to begin and be completed; and

“(B) the results of the review required by subsection (b)(1) are to be reported to the Secretary;

“(2) matters relating to the selection and size of the samples to be reviewed under paragraphs (1) and (2) of subsection (b), and the methodology for making statistically valid estimates of each State’s error rate;

“(3) the period within which a State may seek review by the Quality Control Review Panel of a difference case;

“(4) the period within which a difference case appealed by a State is to be resolved by the Quality Control Review Panel;

“(5) the period, after the completion of the reviews required by paragraphs (1) and (2) of subsection (b) and the resolution by the Quality Control Review Panel of any difference cases appealed by a State, within which the Secretary is to notify the State of the error rate of the State for the fiscal year involved; and

“(6) the period within which the Secretary is to notify a State of any disallowance.

“(i) PAYMENT OF DISALLOWANCES.—

“(1) PAYMENT OPTIONS.—Within 45 days after the date a State is notified of a disallowance pursuant to subsection (g), the State shall, at the option of the State—

“(A) pay the Secretary the amount of the disallowance; or

“(B) enter into an agreement with the Secretary under which the State will make quarterly payments to the Secretary over a period not to exceed 30 months beginning not later than the first quarter beginning after the date the State receives the notice, in amounts sufficient to repay the disallowance with interest by the end of such period.

“(2) AUTHORITY TO ADJUST STATE MATCHING PAYMENTS.—If a State fails to pay the amount of a disallowance imposed on the State, in the manner required by the applicable subparagraph of paragraph (1), the Secretary shall reduce the amount to be paid to the State under section 403(a) by amounts sufficient to recover the amount of the disallowance with interest.

“(3) INTEREST ON UNPAID DISALLOWANCES.—

“(A) RATE OF INTEREST.—Interest on the unpaid amount of a disallowance shall accrue at the overpayment rate established under section 6621(a)(1) of the Internal Revenue Code of 1986.

“(B) ACCRUAL OF INTEREST.—

“(i) IN GENERAL.—Except as provided in clause (ii), interest on the unpaid amount of a State’s disallowance shall accrue beginning 45 days after the date the State receives notice of the disallowance.

“(ii) EXCEPTION.—If the State appeals the imposition of a disallowance under this section to the Departmental Appeals Board and the Board does not decide the appeal within 90 days after the date of the State’s

notice of appeal, interest shall not accrue on the unpaid amount of the disallowance during the period beginning on such 90th day and ending on the date of the Board's final decision on the appeal, except to the extent that the Board finds that the State caused or requested the delay.

"(j) ADMINISTRATIVE REVIEW OF DISALLOWANCES.—

"(1) IN GENERAL.—Within 60 days after the date a State receives notice of a disallowance imposed under this section, the State may appeal the imposition of the disallowance, in whole or in part, to the Departmental Appeals Board established in the Department of Health and Human Services, by filing an appeal with the Board.

"(2) PROCEDURAL RULES.—The Board shall consider a State's appeal on the basis of such documentation as the State may submit and as the Board may require to support the final decision of the Board. In deciding whether to uphold a disallowance or any portion thereof, the Board shall conduct a thorough review of the issues and take into account all relevant evidence. In rendering its final decision, the Board shall incorporate by reference any findings of the Quality Control Review Panel that were made in connection with the determination of the error rate and the amount of the disallowance, and such findings shall not be reviewable by the Board.

"(k) JUDICIAL REVIEW OF DISALLOWANCES.—

"(1) IN GENERAL.—Within 90 days after the date of a final decision by the Departmental Appeals Board with respect to the imposition of a disallowance on a State under this section, the State may obtain judicial review of the final decision (and the findings of the Quality Control Review Panel incorporated into the final decision) by filing an action in—

"(A) the district court of the United States for the judicial district in which the principal or headquarters office of the State agency is located; or

"(B) the United States District Court for the District of Columbia.

"(2) PROCEDURAL RULES.—The district court in which an action is filed shall review the final decision of the Board on the record established in the administrative proceeding, in accordance with the standards of review prescribed by subparagraphs (A) through (E) of section 706(2) of title 5, United States Code. The review shall be on the basis of the documents and supporting data submitted to the Board (or to the Quality Control Review Panel, in the case of any finding by the Panel which is at issue in the appeal).

"(l) REFUND OF DISALLOWANCES IMPOSED IN ERROR.—If the Secretary, directly or indirectly, receives from a State part or all of the amount of a disallowance imposed on the State under this section, and part or all of the disallowance is finally determined to have been imposed in error, the Secretary shall refund to the State the amount received by reason of the error, with interest which shall accrue from the date of receipt at the rate described in subsection (i)(3)(A).

"(m) DEFINITIONS.—As used in this section:

“(1) **NATIONAL AVERAGE ERROR RATE.**—The term ‘national average error rate’ for a fiscal year means the greater of—

“(A) the ratio of—

“(i) the total amount of erroneous payments made by all States for the fiscal year; to

“(ii) the total amount of aid paid by all the States for the fiscal year under plans approved under this part; or

“(B) 4 percent.

“(2) **UNDERPAYMENT RATE.**—The term ‘underpayment rate’, with respect to a State for a fiscal year, means the ratio of—

“(A) the total amounts of aid that should have been but were erroneously not paid for a fiscal year to recipients of aid under the State plan approved under this part; to

“(B) the total amount of aid paid under such plan for the fiscal year.

“(3) **NATIONAL AVERAGE UNDERPAYMENT RATE.**—The term ‘national average underpayment rate’ for a fiscal year means the ratio of—

“(A) the total amounts of aid that should have been but were erroneously not paid for a fiscal year to all recipients of aid under State plans approved under this part; to

“(B) the total amount of aid paid for the fiscal year under all State plans approved under this part.

“(4) **CHILD SUPPORT COLLECTION RATE.**—The term ‘child support collection rate’, with respect to a State for a fiscal year, means the ratio of—

“(A) the sum of the number of cases reported by the agency administering the State plan approved under part D for each quarter in the fiscal year for which—

“(i) an assignment was made under section 402(a)(26); and

“(ii) a collection was made under the State’s plan approved under part D; to

“(B) the sum of the number of cases reported by such agency for each quarter in the fiscal year under which an assignment was made under section 402(a)(26).

“(5) **NATIONAL CHILD SUPPORT COLLECTION RATE.**—The term ‘national child support collection rate’ for a fiscal year means the ratio of—

“(A) the sum of the number of cases described in paragraph (4)(A) reported by all States for quarters in the fiscal year; to

“(B) the sum of the number of cases described in paragraph (4)(B) reported by all States for quarters in the fiscal year.

“(6) **ERRONEOUS PAYMENTS.**—The term ‘erroneous payments’ means the sum of overpayments to eligible families and payments to ineligible families made in carrying out a plan approved under this part.”

(b) **CONFORMING REPEALS.**—Effective October 1, 1990, subsections (i) and (j) of section 403 are hereby repealed.

(c) **APPLICABILITY OF NEW QUALITY CONTROL SYSTEM.**—The amendment made by subsection (a) shall apply to erroneous payments made in any fiscal year after fiscal year 1990.

(d) **NO SANCTIONS WITH RESPECT TO DISALLOWANCES BEFORE FISCAL YEAR 1991.**—No disallowance or other similar sanction shall be applied to a State for any fiscal year before fiscal year 1991 under section 403(i) of the Social Security Act or any predecessor statutory or regulatory provision relating to disallowances for erroneous payments made in carrying out a State plan approved under part A of title IV of such Act.

(e) **IMPLEMENTATION.**—The Secretary of Health and Human Services shall take all actions necessary to assure that adequate numbers of staff are available to perform the functions required by the amendments made by this section.

(f) **ANNUAL REPORTS.**—The Secretary of Health and Human Services shall annually submit to the Committee on Finance of the Senate, and to the Committee on Ways and Means of the House of Representatives a report on whether the time periods contained in the regulations prescribed pursuant to section 408 of the Social Security Act (as added by subsection (a)) have been or will be met. The first such report shall be submitted not later than January 1, 1992.

(g) **STUDY OF NEGATIVE CASE ACTIONS.**—

(1) **IN GENERAL.**—Not later than October 1, 1992, the Secretary of Health and Human Services shall report and make recommendations to the Congress on the results of a study of negative case actions under the program of aid to families with dependent children under State plans approved under part A of title IV of the Social Security Act.

(2) **NEGATIVE CASE ACTIONS DEFINED.**—As used in paragraph (1), the term “negative case actions” means termination of assistance under part A of title IV of the Social Security Act, denial of an application for assistance under such part, or other action with respect to an application under such part without a determination of eligibility for assistance under such part.

SEC. 8005. EMERGENCY ASSISTANCE AND AFDC SPECIAL NEEDS.

(a) **IMPLEMENTATION OF PROPOSED REGULATIONS PROHIBITED.**—Except as provided in subsection (b), the Secretary of Health and Human Services (in this section referred to as the “Secretary”) shall not—

(1) implement in whole or in part the proposed regulation published in the Federal Register on December 14, 1987, (52 F.R. 47420) with respect to emergency assistance and the need for and amount of assistance under the program of aid to families with dependent children; or

(2) before October 1, 1990, change any policy in effect immediately before the date of the enactment of this Act with respect to any of the matters addressed in the proposed regulation.

(b) **REVISED PROPOSED REGULATION.**—Notwithstanding subsection (a), the Secretary may issue a revised proposed regulation concerning the use of emergency assistance under the program of aid to families with dependent children under title IV of the Social Security Act that incorporates the recommendations included in the report entitled “Use of the Emergency Assistance and AFDC Programs to Pro-

vide Shelter to Families" that the Secretary submitted to the Congress on July 3, 1989.

(c) **ESTABLISHMENT OF EFFECTIVE DATES FOR PROPOSED RULES.**—Any final regulation which would change any policy in effect immediately before the date of the enactment of this Act with respect to the use of emergency assistance or special needs funds under the program of aid to families with dependent children under part A of title IV of the Social Security Act shall not take effect before October 1, 1990.

(d) **REPORTING REQUIREMENTS.**—With respect to any calendar quarter beginning on or after January 1, 1990, a financial report by a State submitted to the Secretary to fulfill reporting requirements under the program of aid to families with dependent children under part A of title IV of the Social Security Act shall identify any emergency assistance and special needs funds expended by the State under the program and used to pay for housing in hotels or similar temporary living arrangements (as defined by the Secretary) that house recipients of such aid.

SEC. 8006. INCREASE IN REIMBURSEMENT FOR FOSTER AND ADOPTIVE PARENT TRAINING.

(a) **IN GENERAL.**—Section 474(a)(3) (42 U.S.C. 674(a)(3)) is amended—

- (1) by striking "and" at the end of subparagraph (A);
- (2) by redesignating subparagraph (B) as subparagraph (C); and
- (3) by inserting after subparagraph (A) the following:

"(B) 75 percent of so much of such expenditures (including travel and per diem expenses) as are for the short-term training of current or prospective foster or adoptive parents and the members of the staff of State-licensed or State-approved child care institutions providing care to foster and adopted children receiving assistance under this part, in ways that increase the ability of such current or prospective parents, staff members, and institutions to provide support and assistance to foster and adopted children, whether incurred directly by the State or by contract, and".

(b) **EFFECTIVE DATE.**—The amendments made by subsection (a) shall apply to expenditures made on or after October 1, 1989, and before October 1, 1992.

SEC. 8007. CASE PLANS TO INCLUDE HEALTH AND EDUCATION RECORDS AND TO BE REVIEWED AND UPDATED AT THE TIME OF EACH PLACEMENT.

(a) **INCLUSION OF HEALTH AND EDUCATION RECORDS.**—Section 475(1) (42 U.S.C. 675(1)) is amended—

- (1) by inserting "(A)" before "A description";
- (2) by striking "472(a)(1); and a" and inserting "472(a)(1). (B) A";
- (3) by indenting subparagraphs (A) and (B) (as so amended by paragraphs (1) and (2) of this subsection) 4 ems to the right of the left margin;
- (4) by inserting after and below subparagraph (B) (as so amended and indented) the following:

“(C) To the extent available and accessible, the health and education records of the child, including—

“(i) the names and addresses of the child’s health and educational providers;

“(ii) the child’s grade level performance;

“(iii) the child’s school record;

“(iv) assurances that the child’s placement in foster care takes into account proximity to the school in which the child is enrolled at the time of placement;

“(v) a record of the child’s immunizations;

“(vi) the child’s known medical problems;

“(vii) the child’s medications; and

“(viii) any other relevant health and education information concerning the child determined to be appropriate by the State agency.”; and

(5) by setting the last sentence flush with the left margin of the paragraph.

(b) REVIEW AND UPDATE OF HEALTH AND EDUCATION RECORD AT TIME OF PLACEMENT.—Section 475(5) (42 U.S.C. 675(5)) is amended—

(1) by striking “and” at the end of subparagraph (B);

(2) by striking the period at the end of subparagraph (C) and inserting “; and”; and

(3) by adding at the end the following new subparagraph:

“(D) a child’s health and education record (as described in paragraph (1)(A)) is reviewed and updated, and supplied to the foster parent or foster care provider with whom the child is placed, at the time of each placement of the child in foster care.”.

(c) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) shall take effect on April 1, 1990.

SEC. 8008. ESTABLISHMENT AND CONDUCT OF OUTREACH PROGRAM FOR CHILDREN.

(a) IN GENERAL.—Part B of title XVI (42 U.S.C. 1383 et seq.) is amended by adding at the end the following:

“SEC. 1635. OUTREACH PROGRAM FOR CHILDREN.

“(a) ESTABLISHMENT.—The Secretary shall establish and conduct an ongoing program of outreach to children who are potentially eligible for benefits under this title by reason of disability or blindness.

“(b) REQUIREMENTS.—Under this program, the Secretary shall—

“(1) aim outreach efforts at populations for whom such efforts would be most effective; and

“(2) work in cooperation with other Federal, State, and private agencies, and nonprofit organizations, which serve blind or disabled individuals and have knowledge of potential recipients of supplemental security income benefits, and with agencies and organizations (including school systems and public and private social service agencies) which focus on the needs of children.”.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect 3 months after the date of the enactment of this Act.

SEC. 8009. ELIGIBILITY FOR BENEFITS OF CHILDREN OF ARMED FORCES PERSONNEL RESIDING OVERSEAS.

(a) *IN GENERAL.*—Section 1611(f) (42 U.S.C. 1382(f)) is amended by inserting “(other than a child described in section 1614(a)(1)(B)(ii))” after “no individual”.

(b) *CONFORMING AMENDMENT.*—Section 1614(a)(1) (42 U.S.C. 1382c(a)(1)) is amended—

(1) in subparagraph (B)—

(A) by redesignating clauses (i) and (ii) as subclauses (I) and (II), respectively;

(B) by inserting “(i)” after “(B)”; and

(C) by striking the period and inserting “, or”; and

(2) by adding after and below subparagraph (B) the following:

“(ii) is a child who is a citizen of the United States, who is living with a parent of the child who is a member of the Armed Forces of the United States assigned to permanent duty ashore outside the United States, the District of Columbia, Puerto Rico, and the territories and possessions of the United States, and who, during the month before the parent reported for such assignment, was receiving benefits under this title.”

(c) *EFFECTIVE DATE.*—The amendments made by subsections (a) and (b) shall apply with respect to benefits for months after March 1990.

SEC. 8010. RULE FOR DEEMING TO CHILDREN THE INCOME AND RESOURCES OF THEIR PARENTS WAIVED FOR CERTAIN DISABLED CHILDREN.

(a) *IN GENERAL.*—Section 1614(f)(2) (42 U.S.C. 1382c(f)(2)) is amended—

(1) by inserting “(A)” after “(2)”; and

(2) by adding at the end the following:

“(B) Subparagraph (A) shall not apply in the case of any child who has not attained the age of 18 years who—

“(i) is disabled;

“(ii) received benefits under this title, pursuant to section 1611(e)(1)(B), while in an institution described in section 1611(e)(1)(B);

“(iii) is eligible for medical assistance under a State home care plan approved by the Secretary under the provisions of section 1915(c) relating to waivers, or authorized under section 1902(e)(3); and

“(iv) but for this subparagraph, would not be eligible for benefits under this title.”

(b) *PERSONAL NEEDS ALLOWANCE.*—Section 1611(e)(1)(B) (42 U.S.C. 1382(e)(1)(B)) is amended by inserting “or an eligible individual is a child described in section 1614(f)(2)(B),” before “the benefit under this title”.

(c) *EFFECTIVE DATE.*—The amendments made by subsections (a) and (b) shall take effect on the 1st day of the 6th calendar month beginning after the date of the enactment of this Act.

SEC. 8011. EXCLUSION FROM INCOME OF DOMESTIC COMMERCIAL TRANSPORTATION TICKETS RECEIVED AS GIFTS.

(a) *EXCLUSION FROM INCOME.*—Section 1612(b) (42 U.S.C. 1382a(b)) is amended—

(1) by striking “and” at the end of paragraph (13);

(2) by striking the period at the end of paragraph (14) and inserting “; and”; and

(3) by adding at the end the following:

“(15) the value of any commercial transportation ticket, for travel by such individual (or spouse) among the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands, which is received as a gift by such individual (or such spouse) and is not converted to cash.”

(b) **EFFECTIVE DATE.**—The amendments made by subsection (a) shall take effect on the 1st day of the 3rd calendar month beginning after the date of the enactment of this Act.

SEC. 8012. REDUCTION IN TIME DURING WHICH INCOME AND RESOURCES OF SEPARATED COUPLES MUST BE TREATED AS JOINTLY AVAILABLE.

(a) **IN GENERAL.**—Section 1614(b) (42 U.S.C. 1382c(b)) is amended by striking the 1st sentence and inserting “For purposes of this title, the term ‘eligible spouse’ means an aged, blind, or disabled individual who is the husband or wife of another aged, blind, or disabled individual, and who, in a month, is living with such aged, blind, or disabled individual on the first day of the month or, in any case in which either spouse files an application for benefits or requests restoration of eligibility under this title during the month, at the time the application or request is filed.”

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall take effect on October 1, 1990.

SEC. 8013. EXCLUSION OF ACCRUED INCOME WITH RESPECT TO PURCHASE OF CERTAIN BURIAL SPACES.

(a) **EXCLUSION FROM INCOME.**—Section 1612(b) (42 U.S.C. 1382a(b)), as amended by section 8011(a) of this Act, is amended—

(1) by striking “and” at the end of paragraph (14);

(2) by striking the period at the end of paragraph (15) and inserting “; and”; and

(3) by adding at the end the following:

“(16) interest accrued on the value of an agreement entered into by such individual (or such spouse) representing the purchase of a burial space excluded under section 1613(a)(2)(B), and left to accumulate.”

(b) **EXCLUSION FROM RESOURCES.**—Section 1613(a)(2)(B) (42 U.S.C. 1382b(a)(2)(B)) is amended by inserting “or agreement (including any interest accumulated thereon) representing the purchase of a burial space” after “the value of any burial space”.

(c) **EFFECTIVE DATE.**—The amendments made by subsections (a) and (b) shall take effect on the 1st day of the 4th month beginning after the date of the enactment of this Act.

SEC. 8014. EXCLUSION FROM RESOURCES OF ALL INCOME-PRODUCING PROPERTY.

(a) **IN GENERAL.**—Section 1613(a)(3) (42 U.S.C. 1382b(a)(3)) is amended to read as follows:

“(3) other property which is so essential to the means of self-support of such individual (and such spouse) as to warrant its exclusion, as determined in accordance with and subject to limitations prescribed by the Secretary, except that the Secretary

shall not establish a limitation on property (including the tools of a tradesperson and the machinery and livestock of a farmer) that is used in a trade or business or by such individual as an employee;”.

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall take effect on the 1st day of the 5th calendar month beginning after the date of the enactment of this Act.

SEC. 8015. DEMONSTRATION OF EFFECTIVENESS OF MINNESOTA FAMILY INVESTMENT PLAN.

(a) **IN GENERAL.**—Upon written application of the State of Minnesota (in this section referred to as the “State”) within 24 months after the date of the enactment of this Act, and after the Secretary of Health and Human Services approves the application as meeting the requirements set forth in subsection (b), the State may conduct a demonstration project to determine whether the State family investment plan helps families to become self-supporting and enhances the ability of families to care for their children more effectively than does the State program of aid to families with dependent children under part A of title IV of the Social Security Act.

(b) **PROJECT REQUIREMENTS.**—In an application submitted under subsection (a), the State shall provide that the following terms and conditions shall be in effect under the demonstration project:

(1) **FIELD TRIALS.**—The project will consist of 2 field trials, conducted as follows:

(A) **URBAN FIELD TRIAL.**—1 field trial will be conducted in 1 or more of the following counties in the State:

- (i) Anoka.
- (ii) Carver.
- (iii) Dakota.
- (iv) Hennepin.
- (v) Scott.
- (vi) Washington.

(B) **RURAL FIELD TRIAL.**—1 field trial will be conducted in 1 or more counties in the State not specified in subparagraph (A).

(C) **NUMBER OF FAMILIES INVOLVED.**—The field trials will not involve more than a total of 6,000 families at any one time, excluding families whose sole involvement is as members of control groups needed to evaluate the project.

(2) **AUTHORITY TO IMPLEMENT FIELD TRIALS DIFFERENTLY.**—The implementation of the family investment plan in 1 field trial may be different from the implementation of such plan in the other field trial.

(3) **WAIVERS REQUIRED BEFORE PROJECT BEGINS.**—The project will not begin before all waivers required as described in subsection (e) have been granted.

(4) **BEGINNING OF PROJECT.**—

(A) **IN GENERAL.**—The project will begin during the first month of a calendar quarter.

(B) **BEGIN DEFINED.**—For purposes of this section, the project begins when the first family receives assistance under the project.

(5) **PROJECT TO BE OPERATED IN ACCORDANCE WITH CERTAIN MINNESOTA LAWS.**—*The project will be operated in accordance with the 1989 Minnesota Laws, sections 6 through 11, 13, 130, and 132 of article 5 of chapter 282, and all amendments to the Laws of Minnesota, to the extent that such laws and amendments are consistent with the goals of the project and this subsection.*

(6) **PROJECT PARTICIPANTS INELIGIBLE FOR AFDC.**—*Each family which participates in the project will not be eligible for aid under the State plan approved under section 402(a) of the Social Security Act.*

(7) **MEDICAID ELIGIBILITY RULES APPLICABLE TO PROJECT.**—

(A) **ELIGIBILITY OF PARTICIPANTS.**—

(i) **IN GENERAL.**—*Each family which participates in the project and would (but for such participation) be eligible for aid under the State plan approved under section 402(a) of the Social Security Act will be treated as receiving such aid for purposes of the State plan approved under section 1902(a) of such Act.*

(ii) **ELIGIBILITY EXTENDED FOR PROJECT PARTICIPANTS WITH INCREASED EMPLOYMENT INCOME.**—*Each family which participates in the project and, during such participation, would (but for such participation) become ineligible for aid under the State plan approved under section 402(a) of the Social Security Act by reason of increased income from employment will, for purposes of section 1925 of such Act, be treated as a family that has become ineligible for such aid.*

(B) **ELIGIBILITY EXTENDED FOR PERSONS LEAVING PROJECT BECAUSE OF INCREASED RECEIPT OF CHILD SUPPORT.**—*Each family whose participation in the project is terminated by reason of the collection or increased collection of child support under part D of title IV of the Social Security Act will be treated as a recipient of aid to families with dependent children for purposes of title XIX of such Act for an additional 4 calendar months beginning with the month in which the termination occurs.*

(8) **AFDC RULES TO APPLY GENERALLY.**—

(A) **IN GENERAL.**—*Except where inconsistent with this subsection, the requirements of the State plan approved under section 402(a) of the Social Security Act will apply to the project, unless waived by the Secretary of Health and Human Services in accordance with subsection (d).*

(B) **RULES RELATING TO PARTICIPATION IN EDUCATION, EMPLOYMENT, AND TRAINING ACTIVITIES.**—

(i) **PARTICIPATION GENERALLY NOT REQUIRED.**—*Except as provided in clause (ii), the State will not require any individual who applies for or receives assistance under the project to comply with any education, employment, or training requirement of title IV of the Social Security Act, unless required to do so under a contract entered into under the project.*

(ii) **AUTHORITY TO REQUIRE PARTICIPATION OF PARENT OF CHILD AGE 1 OR OLDER.**—*The State may re-*

quire any individual to comply with any education, employment, or training requirement imposed under the project if the State plan approved under section 402(a) of the Social Security Act does not prohibit the State from requiring such compliance, and the individual—

- (I) receives assistance under the project;
- (II) is the parent or relative of a child who has attained the age of 1 year; and
- (III) is personally providing care for the child.

(9) **AVAILABILITY OF EDUCATION, EMPLOYMENT, AND TRAINING SERVICES.**—The education, employment, and training services available under the State plan approved under part F of title IV of the Social Security Act will be made available to each family required to enter into a contract with a county agency under the 1989 Minnesota Laws, section 10 of article 5 of chapter 282.

(10) **ASSISTANCE UNDER PROJECT NOT LESS THAN UNDER AFDC AND FOOD STAMP PROGRAM.**—

(A) **ESTABLISHMENT OF POLICIES AND STANDARDS.**—The State will establish policies and standards to ensure that families participating in the project receive cash assistance under the project in an amount not less than the aggregate value of the assistance that such families would have received under the State plan approved under section 402(a) of such Act and under the food stamp program established under the Food Stamp Act of 1977 in the absence of the project.

(B) **IDENTIFICATION OF CHARACTERISTICS OF PARTICIPANTS WHO MIGHT RECEIVE LESS BENEFITS THAN UNDER AFDC AND FOOD STAMP PROGRAM.**—The State will identify the set or sets of characteristics of families that (but for this paragraph) might receive benefits under the project in an amount less than the amount required under subparagraph (A) to be provided to such family.

(C) **DETERMINATION OF BENEFIT LEVEL FOR PARTICIPANTS WITH IDENTIFIED CHARACTERISTICS.**—The State will establish a mechanism to determine, for each family with any set of characteristics identified under subparagraph (B), whether the family would (but for this paragraph) receive benefits under the project in an amount less than the amount required under subparagraph (A) to be provided to such family.

(D) **ASSISTANCE UNDER PROJECT INCREASED WHERE NECESSARY.**—The State will, for each family which would (but for this paragraph) receive benefits under the project in an amount less than the amount required under subparagraph (A) to be provided to such family, increase the amount of such benefits to such family to the amount so required.

(11) **TERMINATION OF PROJECT.**—The project will terminate at the end of the 5-year period beginning on the first day of the month during which the project begins, or, if earlier—

(A) 180 days after the State notifies the Secretary of Health and Human Services that the State intends to terminate the project;

(B) 180 days after the Secretary of Health and Human Services, after 30 days written notice to the State and opportunity for a hearing, determines that the State has materially failed to comply with this section; or

(C) on agreement by the State and the Secretary of Health and Human Services.

(c) **FUNDING.**—

(1) **IN GENERAL.**—If an application submitted under subsection (a) by the State complies with the requirements specified in subsection (b) and contains an evaluation plan which meets the requirements of subsection (g), and the Secretary of Health and Human Services approves the application, then the Secretary shall, from amounts made available under parts A and F of title IV of the Social Security Act—

(A) pay the State for each calendar quarter, pursuant to section 403 of such Act, the amounts that would have been payable to the State during such calendar quarter, in the absence of the demonstration project, for cash assistance, child care, education, employment and training, and administrative expenses under the State plan approved under section 402(a) of such Act;

(B) reimburse the State at the rate of 50 percent, for expenses of evaluating the effects of the project.

(2) **RULE OF CONSTRUCTION.**—Paragraph (1) shall not be construed to prevent the State from claiming and receiving reimbursement for additional persons who would qualify for assistance under the State plan approved under section 402(a) of the Social Security Act, for costs attributable to increases in the State's payment standard under such plan, or for any other benefits and services for which Federal matching funds are available under part A of title IV of such Act.

(d) **WAIVER AUTHORITY.**—

(1) **AFDC WAIVERS.**—

(A) **IN GENERAL.**—Except as provided in subparagraph (B), the Secretary of Health and Human Services shall, with respect to the demonstration project under this section, waive any requirement of part A or F of title IV of the Social Security Act that, if applied, would prevent the State from (i) carrying out the project in accordance with subsection (b), or (ii) effectively achieving its purposes, but only to the extent necessary to enable the State to carry out the project.

(B) **LIMITATIONS.**—The Secretary of Health and Human Services may not, with respect to the demonstration project under this section—

(i) waive any requirement of section 402(a)(4) or 482(h) of the Social Security Act;

(ii) permit the State to provide cash assistance to any family under the project in an amount less than the aggregate value of the assistance that would have been provided to such family under the State plan approved

under section 402(a) of such Act and under the food stamp program established under the Food Stamp Act of 1977 in the absence of the project; or

(iii) waive any requirement of section 402(a)(19)(C) of such Act.

(2) **OTHER WAIVERS.**—If, under this section, the Secretary of Health and Human Services approves an application by the State to conduct a demonstration project relating to the State family investment plan, the Secretary of Health and Human Services shall, in order to enable the State to implement the demonstration project—

(A)(i) require that the State treat each family participation as a family that has become ineligible for aid under the State plan approved under part A of title IV of such Act, and

(iii) require that the State treat each family whose participation in the project is terminated by reason of the collection or increased collection of child support under part D of title IV of the Social Security Act as a recipient of aid to families with dependent children for purposes of title XIX of such Act for an additional 4 calendar months beginning with the month in which such termination occurs; and

(B) make payment, under section 1903 of such Act, for medical assistance and administrative expenses for families participating in the project in the same manner as such payments may be made for medical assistance and administrative expenses for individuals entitled to benefits under title XIX of such Act, except that the aggregate amount of such payments may not exceed the aggregate amount of payments that would have been made for those families in the absence of such project.

(e) **DEFINITIONS OF CERTAIN TERMS.**—As used in this section, the terms “family” and “contraci” shall have the meaning given such terms by the 1989 Minnesota Laws, sections 6 through 11, 13, 130, and 132 of article 5 of chapter 282.

(f) **QUALITY CONTROL.**—Cases participating in the demonstration project under this section during a fiscal year shall be excluded from any sample taken for purposes of determining under section 403(i) or 408 of the Social Security Act, whichever is applicable, the rate at which the State made overpayments under part A of title IV of such Act for the fiscal year. For purposes of such sections 403(i) and 408, payments made by the State under the project shall be treated as payments made under the State plan approved under section 402(a) of such Act.

(g) **EVALUATION OF PROJECT.**—

(1) **EVALUATION PLAN.**—The State shall develop and implement an evaluation plan designed to provide reliable information on the impact and implementation of the demonstration project. The evaluation plan shall include groups of project par-

ticipants and control groups assigned at random in the field trial conducted in accordance with subsection (b)(1)(A).

(2) *EVALUATION.*—The evaluation conducted under the evaluation plan shall measure the extent to which the project increases family employment and income, prevents long-term dependency, moves families toward self-support, reduces total assistance payments, and simplifies the welfare system.

(3) *REPORTS.*—The State shall issue an interim report and a final report on the results of the evaluation described in paragraph (2) to the Secretary of Health and Human Services at such times as the Secretary shall require.

(h) *REPORT TO CONGRESS.*—Within 3 months after receipt of the final report issued pursuant to subsection (g)(3), the Secretary of Health and Human Services shall report to the Congress the results of the evaluation described in subsection (g)(2).

SEC. 8016. INCREASE IN FUNDING FOR TITLE XX SOCIAL SERVICES BLOCK GRANT.

Section 2003(c) (42 U.S.C. 1397b(c)) is amended—

(1) in paragraph (3), by striking “and 1987, and for each succeeding fiscal year other than the fiscal year 1988; and” and inserting “1987, and 1989;”;

(2) in paragraph (4), by striking the period and inserting “; and”; and

(3) by adding at the end the following:

“(5) \$2,800,000,000 for each fiscal year after fiscal year 1989.”.

TITLE IX—OFFSHORE OIL POLLUTION COMPENSATION FUND

SEC. 9001. PAYMENTS TO THE OFFSHORE OIL POLLUTION COMPENSATION FUND.

(a) *IN GENERAL.*—(1) Section 302(d)(1) of the Outer Continental Shelf Lands Act Amendments of 1978 (43 U.S.C. 1812(d)(1)) is amended by striking out “not to exceed”.

(2) Section 302(d)(2) of the Outer Continental Shelf Lands Act Amendments of 1978 (43 U.S.C. 1812(d)(2)) is amended by striking out “not less than \$100,000,000 and not more than” and adding in lieu thereof “not more than or less than”.

(b) *EFFECTIVE DATE.*—The amendments made by this section shall take effect on the date of enactment of this Act.

TITLE X—MISCELLANEOUS AND TECHNICAL SOCIAL SECURITY ACT AMENDMENTS

SECTION 10000. SHORT TITLE; TABLE OF CONTENTS.

This title may be cited as the “Miscellaneous and Technical Social Security Act Amendments of 1989”.

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Subtitle A—Time-Sensitive Provisions***SEC. 10101. CONTINUATION OF DISABILITY BENEFITS DURING APPEAL.***

Subsection (g) of section 223 of the Social Security Act (42 U.S.C. 423(g)) is amended—

(1) in paragraph (1)(iii), by striking “June 1990” and inserting “June 1991”; and

(2) in paragraph (3)(B), by striking “January 1, 1990” and inserting “January 1, 1991”.

SEC. 10102. TRANSFER TO RAILROAD RETIREMENT ACCOUNT.

Subsection (c)(1)(A) of section 224 of the Railroad Retirement Solvency Act of 1983 (relating to section 72(r) revenue increase trans-

ferred to certain railroad accounts) is amended by striking "1989" and inserting "1990".

SEC. 10103. EXTENSION OF DISABILITY INSURANCE PROGRAM DEMONSTRATION PROJECT AUTHORITY.

(a) **IN GENERAL.**—Section 505 of the Social Security Disability Amendments of 1980 (Public Law 96-265), as amended by section 12101 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272), is further amended—

(1) in paragraph (3) of subsection (a), by striking "June 10, 1990" and inserting "June 10, 1993";

(2) in paragraph (4) of subsection (a), by striking "in each of the years 1986, 1987, 1988, and 1989" and inserting "in 1986 and each of the succeeding years through 1992"; and

(3) in subsection (c), by striking "June 9, 1990" and inserting "June 9, 1993".

(b) **EFFECTIVE DATE.**—The amendments made by this section shall take effect on the date of the enactment of this Act.

Subtitle B—Technical Provisions

SEC. 10201. PROHIBITION OF TERMINATION OF COVERAGE OF U.S. CITIZENS AND RESIDENTS EMPLOYED ABROAD BY A FOREIGN AFFILIATE OF AN AMERICAN EMPLOYER.

(a) **IN GENERAL.**—Subsection (l) of section 3121 of the Internal Revenue Code of 1986 (relating to agreements entered into by American employers with respect to foreign affiliates) is amended—

(1) in paragraph (2), by adding at the end the following: "Notwithstanding any other provision of this subsection, the period for which any such agreement is effective with respect to any foreign entity shall terminate at the end of any calendar quarter in which the foreign entity, at any time in such quarter, ceases to be a foreign affiliate as defined in paragraph (6).";

(2) by striking paragraphs (3), (4), and (5);

(3) by inserting after paragraph (2) the following new paragraph:

"(3) **NO TERMINATION OF AGREEMENT.**—No agreement under this subsection may be terminated, either in its entirety or with respect to any foreign affiliate, on or after June 15, 1989."; and

(4) by redesignating paragraphs (6) through (10) as paragraphs (4) through (8), respectively.

(b) **CONFORMING AMENDMENTS.**—(1) Subsection (a) of section 210 of the Social Security Act (42 U.S.C. 410(a)) and subsection (a) of section 406 of the Internal Revenue Code of 1986 (relating to treatment of employees of American employer) are each amended by striking "section 3121(l)(8)" and inserting "section 3121(l)(6)".

(2) Paragraph (3) of section 406(c) of the Internal Revenue Code of 1986 (relating to termination of status as deemed employee not be treated as separation from service for purposes of limitation of tax) is amended by striking "section 3121(l)(8)(B)" and inserting "section 3121(l)(6)(B)".

(3) Paragraph (1) of section 3121(l) of such Code (relating to agreements entered into by American employers with respect to foreign af-

filiates) is amended, in the matter preceding subparagraph (A), by striking "paragraph (8)" and inserting "paragraph (6)".

(c) **EFFECTIVE DATE.**—The amendments made by this section shall apply with respect to any agreement in effect under section 3121(l) of the Internal Revenue Code of 1986 on or after June 15, 1989, with respect to which no notice of termination is in effect on such date.

SEC. 10202. EXCLUSION FROM WAGES AND COMPENSATION OF REFUNDS REQUIRED FROM EMPLOYERS TO COMPENSATE FOR DUPLICATION OF MEDICARE BENEFITS BY HEALTH CARE BENEFITS PROVIDED BY THE EMPLOYERS.

(a) **OLD-AGE, SURVIVORS, AND DISABILITY, AND HOSPITAL INSURANCE PROGRAMS.**—For purposes of title II of the Social Security Act and chapter 21 of the Internal Revenue Code of 1986, the term "wages" shall not include the amount of any refund required under section 421 of the Medicare Catastrophic Coverage Act of 1988.

(b) **RAILROAD RETIREMENT PROGRAM.**—For purposes of chapter 22 of the Internal Revenue Code of 1986, the term "compensation" shall not include the amount of any refund required under section 421 of the Medicare Catastrophic Coverage Act of 1988.

(c) **FEDERAL UNEMPLOYMENT PROGRAMS.**—

(1) **FEDERAL UNEMPLOYMENT TAX.**—For purposes of chapter 23 of the Internal Revenue Code of 1986, the term "wages" shall not include the amount of any refund required under section 421 of the Medicare Catastrophic Coverage Act of 1988.

(2) **RAILROAD UNEMPLOYMENT CONTRIBUTIONS.**—For purposes of the Railroad Unemployment Insurance Act, the term "compensation" shall not include the amount of any refund required under section 421 of the Medicare Catastrophic Coverage Act of 1988.

(3) **RAILROAD UNEMPLOYMENT REPAYMENT TAX.**—For purposes of chapter 23A of the Internal Revenue Code of 1986, the term "rail wages" shall not include the amount of any refund required under section 421 of the Medicare Catastrophic Coverage Act of 1988.

(d) **REPORTING REQUIREMENTS.**—Any refund required under section 421 of the Medicare Catastrophic Coverage Act of 1988 shall be reported to the Secretary of the Treasury or his delegate and to the person to whom such refund is made in such manner as the Secretary of the Treasury or his delegate shall prescribe.

(e) **EFFECTIVE DATE.**—This section shall apply with respect to refunds provided on or after January 1, 1989.

SEC. 10203. ELIMINATION OF ANY CARRYOVER REDUCTION IN RETIREMENT OR DISABILITY BENEFITS DUE TO RECEIPT OF WIDOW'S OR WIDOWER'S BENEFITS BEFORE ATTAINING AGE 62.

(a) **IN GENERAL.**—Section 202(q)(3) of the Social Security Act (42 U.S.C. 402(q)(3)) is amended—

(1) by striking subparagraphs (E), (F), and (G); and

(2) by redesignating subparagraph (H) as subparagraph (E).

(b) **EFFECTIVE DATE.**—The amendments made by this section shall apply—

(1) in the case of any individual's old-age insurance benefit referred to in section 202(q)(3)(E) of the Social Security Act (as in effect before the amendments made by this section), only if such individual attains age 62 on or after January 1, 1990, and

(2) in the case of any individual's disability insurance benefit referred to in section 202(q)(3)(F) or (G) of such Act (as so in effect), only if such individual both attains age 62 and becomes disabled on or after such date.

SEC. 10204. CLARIFICATION OF RULES GOVERNING TAXATION UNDER FICA AND SECA OF INDIVIDUALS OF CERTAIN RELIGIOUS FAITHS.

(a) EXEMPTION FROM SECA TAXATION FOR CERTAIN EMPLOYEES EXEMPT FROM FICA TAXATION.—

(1) *IN GENERAL.*—Paragraph (3) of section 1402(g) of the Internal Revenue Code of 1986 (relating to inapplicability of exemption to certain church employees) is amended—

(A) in the heading, by striking “NOT TO APPLY” and inserting “TO APPLY”; and

(B) by striking “shall not” and inserting “shall”.

(2) *EFFECTIVE DATE.*—The amendments made by paragraph (1) shall apply with respect to taxable years beginning after December 31, 1989.

(b) TECHNICAL AMENDMENT CLARIFYING INCLUSION OF PARTNERSHIPS AMONG EMPLOYERS ELIGIBLE FOR RELIGIOUS EXEMPTION FROM FICA.—

(1) *IN GENERAL.*—Section 3127 of the Internal Revenue Code of 1986 (relating to exemption for employers and their employees where both are members of religious faiths opposed to participation in Social Security Act programs) is amended—

(A) in subsection (a)(1), by inserting “(or, if the employer is a partnership, each partner therein)” after “an employer”;

(B) in subsection (a), in the matter following paragraph (2), by striking “his employees” and inserting “the employees thereof”;

(C) in subsection (b), by inserting “(or a partner)” after “an employer”;

(D) in subsection (c), by striking “his employees” and inserting “the employees thereof”;

(E) in subsection (c)(1), by inserting “(or, if the employer is a partnership, each partner therein)” after “such employer”;

(F) in subsection (c)(2), by striking “such employer or the employee involved ceases to meet” and inserting “such employer (or, if the employer is a partnership, any partner therein) or the employee involved does not meet”, and by inserting “(or, if the employer is a partnership, any partner therein)” after “such employer” the second place it appears.

(2) *EFFECTIVE DATE.*—The amendments made by this subsection shall be effective as if they were included in the amendments made by section 8007(a)(1) of the Technical and Miscellaneous Revenue Act of 1988 (102 Stat. 3781).

SEC. 10205. TREATMENT OF GROUP-TERM LIFE INSURANCE UNDER RAILROAD RETIREMENT TAXES.

(a) *IN GENERAL.*—The second sentence of section 3231(e)(1) of the Internal Revenue Code of 1986 (defining compensation) is amended by striking “, (ii) tips” and inserting “or death, except that this clause does not apply to a payment for group-term life insurance to

the extent that such payment is includible in the gross income of the employee, (ii) tips”.

(b) EFFECTIVE DATE.—

(1) **IN GENERAL.**—Except as provided in paragraph (2), the amendment made by subsection (a) shall apply to—

(A) group-term life insurance coverage in effect after December 31, 1989, and

(B) remuneration paid before January 1, 1990, which the employer treated as compensation when paid.

(2) **EXCEPTION.**—The amendment made by subsection (a) shall not apply with respect to payments by the employer (or a successor of such employer) for group-term life insurance for such employer's former employees who separated from employment with the employer on or before December 31, 1989, to the extent that such payments are not for coverage for any such employee for any period for which such employee is employed by such employer (or a successor of such employer) after the date of such separation.

(3) **BENEFIT DETERMINATIONS TO TAKE INTO ACCOUNT REMUNERATION ON WHICH TAX PAID.**—The term “compensation” as defined in section 1(h) of the Railroad Retirement Act of 1974 includes any remuneration which is included in the term “compensation” as defined in section 3231(e)(1) of the Internal Revenue Code of 1986 by reason of the amendment made by subsection (a).

SEC. 10206. TREATMENT OF CERTAIN DEFERRED COMPENSATION AND SALARY REDUCTION ARRANGEMENTS UNDER RAILROAD RETIREMENT TAXES.

(a) **IN GENERAL.**—The second sentence of section 3231(e)(1) of the Internal Revenue Code of 1986 (defining compensation) is amended by striking “or (iii)” and inserting “(iii)” and by inserting before the period “, or (iv) any remuneration which would not (if chapter 21 applied to such remuneration) be treated as wages (as defined in section 3121(a)) by reason of section 3121(a)(5)”.

(b) **TREATMENT OF CERTAIN DEFERRED COMPENSATION AND SALARY REDUCTION ARRANGEMENTS.**—Subsection (e) of section 3231 of such Code is amended by adding at the end thereof the following new paragraph:

“(9) **TREATMENT OF CERTAIN DEFERRED COMPENSATION AND SALARY REDUCTION ARRANGEMENTS.**—

“(A) **CERTAIN EMPLOYER CONTRIBUTIONS TREATED AS COMPENSATION.**—Nothing in any paragraph of this subsection (other than paragraph (2)) shall exclude from the term ‘compensation’ any amount described in subparagraph (A) or (B) of section 3121(v)(1).

“(B) **TREATMENT OF CERTAIN NONQUALIFIED DEFERRED COMPENSATION.**—The rules of section 3121(v)(2) which apply for purposes of chapter 21 shall also apply for purposes of this chapter.”

(c) EFFECTIVE DATES.—

(1) **SUBSECTION (a).**—The amendment made by subsection (a) shall apply to remuneration paid after December 31, 1989.

(2) **SUBSECTION (b).**—Except as otherwise provided in this subsection—

(A) *IN GENERAL.*—The amendment made by subsection (b) shall apply to—

- (i) remuneration paid after December 31, 1989, and
- (ii) remuneration paid before January 1, 1990, which the employer treated as compensation when paid.

(B) *BENEFIT DETERMINATIONS TO TAKE INTO ACCOUNT REMUNERATION ON WHICH TAX PAID.*—The term “compensation” as defined in section 1(h) of the Railroad Retirement Act of 1974 includes any remuneration which is included in the term “compensation” as defined in section 3231(e)(1) of the Internal Revenue Code of 1986 by reason of the amendment made by subsection (b).

(3) *SPECIAL RULE FOR CERTAIN PAYMENTS.*—For purposes of applying the amendment made by subsection (b) to remuneration paid after December 31, 1989, which would have been taken into account before January 1, 1990, if such amendments had applied to periods before January 1, 1990, such remuneration shall be taken into account when paid (or, at the election of the payor, at the time which would be appropriate if such amendments had applied).

(4) *EXCEPTION FOR CERTAIN 401(k) CONTRIBUTIONS.*—The amendment made by subsection (b) shall not apply to employer contributions made during 1990 and attributable to services performed during 1989 under a qualified cash or deferred arrangement (as defined in section 401(k) of the Internal Revenue Code of 1986) if, under the terms of the arrangement as in effect on June 15, 1989—

(A) the employee makes an election with respect to such contributions before January 1, 1990, and

(B) the employer identifies the amount of such contribution before January 1, 1990.

(5) *SPECIAL RULE WITH RESPECT TO NONQUALIFIED DEFERRED COMPENSATION PLANS.*—In the case of an agreement in existence on June 15, 1989, between a nonqualified deferred compensation plan (as defined in section 3121(v)(2)(C) of such Code) and an individual, the amendment made by subsection (b) shall apply with respect to services performed by the individual after December 31, 1989. The preceding sentence shall not apply in the case of a plan to which section 457(a) of such Code applies.

SEC. 10207. TREATMENT OF ROWAN DECISION UNDER RAILROAD RETIREMENT TAXES.

(a) *EXCLUSION OF MEALS AND LODGING.*—Subsection (e) of section 3231 of the Internal Revenue Code of 1986 is further amended by adding at the end the following new paragraph:

“(10) *MEALS AND LODGING.*—The term ‘compensation’ shall not include the value of meals or lodging furnished by or on behalf of the employer if at the time of such furnishing it is reasonable to believe that the employee will be able to exclude such items from income under section 119.”

(b) *INCOME TAX WITHHOLDING REGULATIONS NOT TO APPLY.*—Paragraph (1) of section 3231(e) of such Code is amended by adding at the end the following new sentence: “Nothing in the regulations prescribed for purposes of chapter 24 (relating to wage withholding)

which provides an exclusion from 'wages' as used in such chapter shall be construed to require a similar exclusion from 'compensation' in regulations prescribed for purposes of this chapter."

(c) **EFFECTIVE DATE.**—The amendments made by this section shall apply to remuneration paid after December 31, 1989.

SEC. 10208. INCLUSION OF CERTAIN DEFERRED COMPENSATION IN DETERMINATION OF WAGE-BASED ADJUSTMENTS.

(a) **IN GENERAL.**—Section 209 of the Social Security Act (42 U.S.C. 409) is amended by adding at the end the following new subsection:

"(k)(1) For purposes of sections 203(f)(8)(B)(ii), 213(d)(2)(B), 215(a)(1)(B)(ii), 215(b)(3)(A)(ii), 224(f)(2)(B), and 230(b)(2) (and 230(b)(2) as in effect immediately prior to the enactment of the Social Security Amendments of 1977), the term 'deemed average total wages' for any particular calendar year means the product of—

"(A) the SSA average wage index (as defined in section 215(i)(1)(G) and promulgated by the Secretary) for the calendar year preceding such particular calendar year, and

"(B) the quotient obtained by dividing—

"(i) the average of total wages (as defined in regulations of the Secretary and computed without regard to the limitation specified in subsection (a)(1) and by including deferred compensation amounts) reported to the Secretary of the Treasury or his delegate for such particular calendar year, by

"(ii) the average of total wages (as so defined and computed) reported to the Secretary of the Treasury or his delegate for the calendar year preceding such particular calendar year.

"(2) For purposes of paragraph (1), the term 'deferred compensation amount' means—

"(A) any amount excluded from gross income under chapter 1 of the Internal Revenue Code of 1986 by reason of section 402(a)(8), 402(h)(1)(B), or 457(a) of such Code or by reason of a salary reduction agreement under section 403(b) of such Code,

"(B) any amount with respect to which a deduction is allowable under chapter 1 of such Code by reason of a contribution to a plan described in section 501(c)(18) of such Code, and

"(C) to the extent provided in regulations of the Secretary, deferred compensation provided under any arrangement, agreement, or plan referred to in subsection (i) or (j)."

(b) **CONFORMING AMENDMENTS.**—

(1) Sections 203(f)(8)(B)(ii), 215(b)(3)(A)(ii), and 230(b)(2)(a) of the Social Security Act (42 U.S.C. 403(f)(8)(B)(ii)(I), 415(b)(3)(A)(ii)(I), and 430(b)(2)(A)), as amended by subsection (d)(2)(A)(i), are each further amended—

(A) by striking "the average of the total wages (as defined in regulations of the Secretary and computed without regard to the limitations specified in section 209(a)(1)) reported to the Secretary of the Treasury or his delegate" and inserting "the deemed average total wages (as defined in section 209(k)(1))";

(B) by striking "the average of the total wages (as so defined and computed) reported to the Secretary of the Treasury or his delegate" and inserting "the deemed average total wages (as so defined)"; and

(C) in section 215(b)(3)(A)(ii)(I), by striking "(after 1976)".

(2) Sections 213(d)(2)(B), 215(a)(1)(B)(ii), and 224(f)(2)(B) of such Act (42 U.S.C. 413(d)(2)(B), 415(a)(1)(B)(ii), and 424a(f)(2)(B)), as amended by subsection (d)(2)(A)(i), as each further amended—

(A) by striking "the average of the total wages (as defined in regulations of the Secretary and computed without regard to the limitations specified in section 209(a)(1)) reported to the Secretary of the Treasury or his delegate" and inserting "the deemed average total wages (as defined in section 209(k)(1))";

(B) in section 213(d)(2)(B) and 215(a)(1)(B)(ii)(II), by striking "(as so defined and computed)" and inserting "(as defined in regulations of the Secretary and computed without regard to the limitations specified in section 209(a)(1))"; and

(C) in section 224(f)(2)(B)(ii), by inserting "(I)" after "(ii)", by striking "as so defined and computed)" and inserting "(as defined in regulations of the Secretary and computed without regard to the limitations specified in section 209(a)(1))", and by inserting after "disability)" the following: ", if such calendar year is before 1991, or (II) the deemed average total wages (as defined in section 209(k)(1)) for the calendar year before the year in which the reduction was first computed (but not counting any reduction made in benefits for a previous period of disability), if such calendar year is after 1990".

(3) Section 215(i)(1)(G) of such Act (42 U.S.C. 415(i)(1)(G)) is amended by striking "the average of the total wages reported to the Secretary of the Treasury or his delegate as determined for purposes of subsection (b)(3)(A)(ii)" and inserting "the amount determined for such calendar year under subsection (b)(3)(A)(ii)(I)".

(4) Section 215(a)(1)(C)(ii) of such Act (42 U.S.C. 415(a)(1)(C)(ii)) is amended by striking "change." and inserting "change (except that, for purposes of subsection (b)(2)(A) of such section 230 as so in effect, the reference therein to the average of the wages of all employees as reported to the Secretary of the Treasury for any calendar year shall be deemed a reference to the deemed average total wages (within the meaning of section 209(k)(1)) for such calendar year).".

(5) Section 230(d) of such Act (42 U.S.C. 430(d)) is amended by striking "change." and inserting "change (except that, for purposes of subsection (b)(2)(A) of such section 230 as so in effect, the reference therein to the average of the wages of all employees as reported to the Secretary of the Treasury for any calendar year shall be deemed a reference to the deemed average total wage (within the meaning of section 209(k)(1)) for such calendar year).".

(c) **EFFECTIVE DATE.**—

(1) *IN GENERAL.*—The amendments made by subsections (a) and (b) shall apply with respect to the computation of average total wage amounts (under the amended provisions) for calendar years after 1990.

(2) *TRANSITIONAL RULE.*—For purposes of determining the contribution and benefit base for 1990, 1991, and 1992 under section 230(b) of the Social Security Act (and section 230(b) of such Act as in effect immediately prior to enactment of the Social Security Amendments of 1977)—

(A) the average of total wages for 1988 shall be deemed to be equal to the amount which would have been determined with regard to this paragraph, plus 2 percent of the amount which has been determined to be the average of total wages for 1987,

(B) the average of total wages for 1989 shall be deemed to be equal to the amount which would have been determined without regard to this paragraph, plus 2 percent of the amount which would have been determined to be the average of total wages for 1988 without regard to subparagraph (A), and

(C) the average of total wages reported to the Secretary of the Treasury for 1990 shall be deemed to be equal to the product of—

(i) the SSA average wage index (as defined in section 215(i)(1)(G) of the Social Security Act and promulgated by the Secretary) for 1989, and

(ii) the quotient obtained by dividing—

(I) the average of total wages (as defined in regulations of the Secretary and computed without regard to the limitations of section 209(a)(1) of the Social Security Act and by including deferred compensation amounts, within the meaning of section 209(k)(2) of such Act as added by this section) reported to the Secretary of the Treasury or his delegate for 1990, by

(II) the average of total wages (as so defined and computed without regard to the limitations specified in such section 209(a)(1) and by excluding deferred compensation amounts within the meaning of such section 209(k)(2)) reported to the Secretary of the Treasury or his delegate for 1989.

(3) *DETERMINATION OF CONTRIBUTION AND BENEFIT BASE FOR 1993.*—For purposes of determining the contribution and benefit base for 1993 under section 230(b) of the Social Security Act (and section 230(b) of such Act as in effect immediately prior to enactment of the Social Security Amendments of 1977), the average of total wages for 1990 shall be determined without regard to subparagraph (C) of paragraph (2).

(4) *REVISED DETERMINATION UNDER SECTION 230 OF THE SOCIAL SECURITY ACT.*—As soon as possible after the enactment of this Act, the Secretary of Health and Human Services shall revise and publish, in accordance with the provisions of this Act and the amendments made thereby, the contribution and benefit base under section 230 of the Social Security Act with

respect to remuneration paid after 1989 and taxable years beginning after calendar year 1989.

(d) CLERICAL AMENDMENTS.—

(1) DESIGNATION OF UNDESIGNATED PROVISIONS.—Section 209 of the Social Security Act is further amended—

(A) by redesignating paragraphs (1) through (9) of subsection (a) as subparagraphs (A) through (I), respectively;

(B) by redesignating clauses (1) through (3) of subsection (b) as clauses (A) through (B), respectively;

(C) by redesignating clauses (1) through (9) of subsection (e) as clauses (A) through (I), respectively;

(D) by redesignating paragraphs (1) and (2) of subsection (f) as subparagraphs (A) and (B), respectively;

(E) by redesignating paragraphs (1), (2), and (3) of subsection (g) as subparagraph (A), (B), and (C), respectively;

(F) in subsection (h), by redesignating clauses (1), (ii), and (iii) as clauses (I), (II), and (III), respectively, by redesignating subparagraphs (A) and (B) of paragraph (2) as clauses (i) and (ii), respectively, and by redesignating paragraphs (1) and (2) as subparagraphs (A) and (B), respectively;

(G) by redesignating paragraphs (1) and (2) of subsection (1) as subparagraphs (A) and (B), respectively;

(H) by redesignating paragraphs (1) and (2) of subsection (m) as subparagraphs (A) and (B), respectively;

(I) by redesignating paragraphs (1) and (2) of subsection (p) as subparagraphs (A) and (B), respectively;

(J) by redesignating subsections (a), (b), (d), (e), (f), (g), (h), (j), (k), (l), (m), (n), (o), (p), (q), (r), (s), and (t) (in the matter preceding subsection (k) added by subsection (a) of this section, and as amended by the preceding provisions of this paragraph) as paragraphs (1), (2), (3), (4), (5), (6), (7), (8), (9), (10), (11), (12), (13), (14), (15), (16), (17), and (18), respectively;

(K) by inserting “(a)” after “SEC. 209.”;

(L) by striking “Nothing in the regulations” and inserting the following:

“(b) Nothing in the regulations”;

(M) in the undesignated paragraph commencing with “For purposes of this title, in the case of domestic service”, by inserting “(c)” at the beginning thereof, and by striking “subsection (g)(2)” each place it appears and inserting “subsection (a)(6)(B)”;

(N) in the undesignated paragraph commencing with “For purposes of this title, in the case of an individual performing service, as a member”, by inserting “(d)” at the beginning thereof, and by striking “subsection (a)” and inserting “subsection (a)(1)”;

(O) by inserting “(e)” at the beginning of the undesignated paragraph commencing with “For purposes of this title, in the case of an individual performing service, as a volunteer”;

(P) by inserting “(f)” at the beginning of the undesignated paragraph commencing with “For purposes of this title, tips received”;

(Q) by inserting "(g)" at the beginning of the undesignated paragraph commencing with "For purposes of this title, in any case where";

(R) by inserting "(h)" at the beginning of the undesignated paragraph commencing with "For purposes of this title, in the case of an individual performing service under the provisions";

(S) by inserting "(i)" at the beginning of the undesignated paragraph commencing with "Nothing in any of the foregoing"; and

(T) by inserting "(j)" at the beginning of the undesignated paragraph commencing with "Any amount deferred".

(2) CONFORMING AMENDMENTS.—

(A) Title II of such Act is amended—

(i) in sections 203(f)(8)(B)(ii)(I), 213(d)(2)(B), 215(a)(B)(ii)(I), 215(b)(3)(A)(ii)(I), 224(f)(2)(B)(i), and 230(b)(2)(A) (42 U.S.C. 403(f)(8)(B)(ii)(I), 413(d)(2)(B), 415(a)(1)(B)(ii)(I), 415(b)(3)(A)(ii)(I), 424a(f)(2)(B)(i), and 430(b)(2)(A)), by striking "section 209(a)" and inserting "section 209(a)(1)";

(ii) in section 203(f)(5)(C), by striking "subsections (a), (g)(2), (g)(3), (h)(2), and (j) of section 209" and inserting "paragraphs (1), (6)(B), (6)(C), (7)(B), and (8) of section 209(a)";

(iii) in clauses (B) and (C) of the last sentence of section 224(a), by striking "209(a)" and inserting "209(a)(1)";

(iv) in section 217(b)(1), by striking "209(e)(2)" and inserting "209(a)(4)(B)";

(v) in section 218(c)(5) by striking "paragraph (2) of section 209(h)" and inserting "subparagraph (B) of section 209(a)(7)"; and

(vi) in section 203(f)(5)(C)(ii), by striking "209(m)(2)" and inserting "209(a)(11)(B)".

(B)(i) Section 6(f)(1) of the Fair Labor Standards Act of 1938 (29 U.S.C. 206(f)(1)) is amended by striking "209(g) and inserting "209(a)(6)".

(ii) Section 1(h)(5)(iii) of the Railroad Retirement Act of 1974 (45 U.S.C. 231(h)(5)(iii)) is amended by striking "the third paragraph of section 209" and inserting "section 209(d)".

Subtitle C—Additional Amendments

SEC. 10301. ELIMINATION OF THE DEPENDENCY TEST APPLICABLE TO CERTAIN ADOPTED CHILDREN.

(a) IN GENERAL.—Section 202(d)(8)(D) of the Social Security Act (42 U.S.C. 402(d)(8)(D)) is amended—

(1) by adding "and" after the comma at the end of clause (i); and

(2) by striking clauses (ii) and (iii) and inserting the following new clause:

"(ii) in the case of a child who attained the age of 18 prior to the commencement of proceedings for adoption, the child was living with or receiving at least one-half of the child's support from such individual for the year

immediately preceding the month in which the adoption is decreed.”.

(b) **CONFORMING AMENDMENT.**—Paragraph (8) of section 202(d) of such Act is further amended by striking the last sentence.

(c) **EFFECTIVE DATE.**—The amendments made by this section shall apply with respect to benefits payable for months after December 1989, but only on the basis of applications filed on or after January 1, 1990.

SEC. 10302. AUTHORITY FOR SECRETARY TO TAKE INTO ACCOUNT MISINFORMATION PROVIDED TO APPLICANTS IN DETERMINING DATE OF APPLICATION FOR BENEFITS.

(a) **OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE.**—

(1) **IN GENERAL.**—Section 202(j) of the Social Security Act (42 U.S.C. 402(j)) is amended by adding at the end the following new paragraph:

“(5) In any case in which it is determined to the satisfaction of the Secretary that an individual failed as of any date to apply for monthly insurance benefits under this title by reason of misinformation provided to such individual by any officer or employee of the Social Security Administration relating to such individual’s eligibility for benefits under this title, such individual shall be deemed to have applied for such benefits on the later of—

“(A) the date on which such misinformation was provided to such individual, or

“(B) the date on which such individual met all requirements for entitlement to such benefits (other than application therefor).”.

(2) **EFFECTIVE DATE.**—The amendment made by paragraph (1) shall apply with respect to misinformation furnished after December 1982 and to benefits for months after December 1982.

(b) **SUPPLEMENTAL SECURITY INCOME.**—

(1) **IN GENERAL.**—Section 1631(e) of such Act (42 U.S.C. 1383(e)) is amended by adding at the end the following new paragraph:

“(5) In any case in which it is determined to the satisfaction of the Secretary that an individual failed as of any date to apply for benefits under this title by reason of misinformation provided to such individual by any officer or employee of the Social Security Administration relating to such individual’s eligibility for benefits under this title, such individual shall be deemed to have applied for such benefits on the later of—

“(A) the date on which such misinformation was provided to such individual, or

“(B) the date on which such individual met all requirements for entitlement to such benefits (other than application therefor).”.

(2) **EFFECTIVE DATE.**—The amendment made by paragraph (1) shall apply with respect to misinformation furnished on or after the date of the enactment of this Act and to benefits for months after the month in which this Act is enacted.

SEC. 10303. SAME-DAY PERSONAL INTERVIEWS AT FIELD OFFICES OF THE SOCIAL SECURITY ADMINISTRATION IN CERTAIN CASES WHERE TIME IS OF THE ESSENCE.

(a) **OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE.**—Section 205 of the Social Security Act (42 U.S.C. 405) is amended by adding at the end the following new subsection:

*"Same-Day Personal Interviews at Field Offices in Cases Where
Time Is of the Essence*

"(t) In any case in which an individual visits a field office of the Social Security Administration and represents during the visit to an officer or employee of the Social Security Administration in the office that the individual's visit is occasioned by—

*"(1) the receipt of a notice from the Social Security Administration indicating a time limit for response by the individual,
or*

"(2) the theft, loss, or nonreceipt of a benefit payment under this title,

the Secretary shall ensure that the individual is granted a face-to-face interview at the office with an officer or employee of the Social Security Administration before the close of business on the day of the visit."

(b) SUPPLEMENTAL SECURITY INCOME.—Section 1631(e) of such Act (42 U.S.C. 1383(e)) is amended by adding after the paragraph added by section 10302(b)(1) of this Act the following new paragraph:

"(6) In any case in which an individual visits a field office of the Social Security Administration and represents during the visit to an officer or employee of the Social Security Administration in the office that the individual's visit is occasioned by—

*"(1) the receipt of a notice from the Social Security Administration indicating a time limit for response by the individual,
or*

"(2) the theft, loss, or nonreceipt of a benefit payment under this title,

the Secretary shall ensure that the individual is granted a face-to-face interview at the office with an officer or employee of the Social Security Administration before the close of business on the day of the visit."

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to visits to field offices of the Social Security Administration on or after January 1, 1990.

SEC. 10304. AUTHORITY TO AMEND WAGE RECORDS AFTER EXPIRATION OF TIME LIMITATION.

Subparagraph (H) of section 205(c)(5) of the Social Security Act (42 U.S.C. 405(c)(5)(H)) is amended by striking "if" and all that follows through "period".

SEC. 10305. STANDARDS APPLICABLE IN CERTAIN DETERMINATIONS OF GOOD CAUSE, FAULT, AND GOOD FAITH.

(a) GOOD CAUSE FOR FAILURE TO MAKE EARNINGS REPORTS TIMELY.—Section 203(l) of the Social Security Act (42 U.S.C. 403(l)) is amended in the last sentence by striking "Secretary" and inserting "Secretary, except that in making any such determination, the Secretary shall specifically take into account any physical, mental, educational, or linguistic limitation such individual may have (including any lack of facility with the English language)".

(b) WAIVERS OF RECOVERY OF OVERPAYMENTS.—Section 204(b) of such Act (42 U.S.C. 404(b)) is amended by adding at the end the following new sentence: "In making for purposes of this subsection any determination of whether any individual is without fault, the Secretary shall specifically take into account any physical, mental, edu-

cational, or linguistic limitation such individual may have (including any lack of facility with the English language).”

(c) **STANDARD OF REVIEW IN TERMINATION OF DISABILITY BENEFITS.**—Section 223(f) of such Act (42 U.S.C. 423(f)) is amended by inserting after the first sentence in the matter following paragraph (4) the following new sentence: “In making for purposes of the preceding sentence any determination relating to fraudulent behavior by any individual or failure by any individual without good cause to cooperate or to take any required action, the Secretary shall specifically take into account any physical, mental, educational, or linguistic limitation such individual may have (including any lack of facility with the English language).”

(d) **CONTINUATION OF BENEFITS PENDING APPEAL.**—Section 223(g)(2)(B) of such Act (42 U.S.C. 423(g)(2)(B)) is amended by adding at the end the following new sentence: “In making for purposes of this subparagraph any determination of whether any individual’s appeal is made in good faith, the Secretary shall specifically take into account any physical, mental, educational, or linguistic limitation such individual may have (including any lack of facility with the English language).”

(e) **SUPPLEMENTAL SECURITY INCOME.**—Section 1631(c)(1) of such Act (42 U.S.C. 1383(c)(1)) is amended by adding at the end the following: “The Secretary shall specifically take into account any physical, mental, educational, or linguistic limitation of such individual (including any lack of facility with the English language) in determining, with respect to the eligibility of such individual for benefits under this title, whether such individual acted in good faith or was at fault, and in determining fraud, deception, or intent.”

(f) **EFFECTIVE DATE.**—The amendments made by this section shall apply with respect to determinations made on or after July 1, 1990.

SEC. 10306. NOTICE REQUIREMENTS.

(a) **APPLICABILITY TO BLIND BENEFICIARIES UNDER TITLE II OF NOTICE STANDARDS CURRENTLY APPLICABLE TO BLIND BENEFICIARIES UNDER TITLE XVI.**—

(1) **IN GENERAL.**—Section 221 of the Social Security Act (42 U.S.C. 421) is amended by adding at the end the following new subsection:

“(1)(1) In any case where an individual who is applying for or receiving benefits under this title on the basis of disability by reason of blindness is entitled to receive notice from the Secretary of any decision or determination made or other action taken or proposed to be taken with respect to his or her rights under this title, such individual shall at his or her election be entitled either (A) to receive a supplementary notice of such decision, determination, or action, by telephone, within 5 working days after the initial notice is mailed, (B) to receive the initial notice in the form of a certified letter, or (C) to receive notification by some alternative procedure established by the Secretary and agreed to by the individual.

“(2) The election under paragraph (1) may be made at any time, but an opportunity to make such an election shall in any event be given, to every individual who is an applicant for benefits under this title on the basis of disability by reason of blindness, at the time of his or her application. Such an election, once made by an

individual, shall apply with respect to all notices of decisions, determinations, and actions which such individual may thereafter be entitled to receive under this title until such time as it is revoked or changed.”.

(2) **APPLICATION TO CURRENT RECIPIENTS.**—Not later than July 1, 1990, the Secretary of Health and Human Services shall provide every individual receiving benefits under title II of the Social Security Act on the basis of disability by reason of blindness an opportunity to make an election under section 221(l)(1) of such Act (as added by paragraph (1)).

(3) **EFFECTIVE DATE.**—The amendment made by this section shall apply with respect to notices issued on or after July 1, 1990.

(b) **REPORT REGARDING NOTICES IN LANGUAGES OTHER THAN ENGLISH.**—Not later than January 1, 1991, the Secretary of Health and Human Services shall submit a report to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate setting forth—

(1) the procedures of the Social Security Administration currently in effect for issuing notices in languages other than English to individuals who have a limited capacity to communicate with such Administration in English, and

(2) reasonable options for expanding the use of notices in languages other than English.

SEC. 10307. REPRESENTATION OF CLAIMANTS.

(a) **RECORDING OF IDENTITY OF REPRESENTATIVES IN ELECTRONIC INFORMATION RETRIEVAL SYSTEM.**—

(1) **OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE.**—Section 206(a) of the Social Security Act (42 U.S.C. 406(a)) is amended by adding at the end the following new sentence: “The Secretary shall maintain in the electronic information retrieval system used by the Social Security Administration a current record, with respect to any claimant before the Secretary, of the identity of any person representing such claimant in accordance with this subsection.”.

(2) **SUPPLEMENTAL SECURITY INCOME.**—Section 1631(d)(2) of such Act (42 U.S.C. 1383(d)(2)) is amended by adding at the end the following new sentence: “The Secretary shall maintain in the electronic information retrieval system used by the Social Security Administration a current record, with respect to any claimant before the Secretary, of the identity of any person representing such claimant in accordance with this paragraph.”.

(3) **EFFECTIVE DATE.**—The amendments made by this subsection shall take effect June 1, 1991.

(b) **NOTIFICATION OF OPTIONS FOR OBTAINING ATTORNEYS.**—

(1) **OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE.**—Section 206 of such Act (42 U.S.C. 406) is further amended by adding at the end the following new subsection:

“(c) The Secretary shall notify each claimant in writing, together with the notice to such claimant of an adverse determination, of the options for obtaining attorneys to represent individuals in presenting their cases before the Secretary. Such notification shall also advise the claimant of the availability to qualifying claimants of

legal services organizations which provide legal services free of charge.”.

(2) **SUPPLEMENTAL SECURITY INCOME.**—Section 1631(d)(2) of such Act (42 U.S.C. 1383(d)(2)) is amended—

(A) by inserting “(A)” after “(2)”; and

(B) by adding at the end the following new subparagraph:

“(B) The Secretary shall notify each claimant in writing, together with the notice to such claimant of an adverse determination, of the options for obtaining attorneys to represent individuals in presenting their cases before the Secretary. Such notification shall also advise the claimant of the availability to qualifying claimants of legal services organizations which provide legal services free of charge.”.

(3) **EFFECTIVE DATE.**—The amendments made by this subsection shall apply with respect to adverse determinations made on or after January 1, 1991.

SEC. 10308. EARNINGS AND BENEFIT STATEMENTS.

Part A of title XI of the Social Security Act is amended by adding at the end thereof the following new section:

“SOCIAL SECURITY ACCOUNT STATEMENTS

“Provision Upon Request

“SEC. 1142. (a)(1) Beginning not later than October 1, 1990, the Secretary shall provide upon the request of an eligible individual a social security account statement (hereinafter referred to as the ‘statement’).

“(2) Each statement shall contain—

“(A) the amount of wages paid to and self-employment income derived by the eligible individual as shown by the records of the Secretary at the date of the request;

“(B) an estimate of the aggregate of the employee and self-employment contributions of the eligible individual for old-age, survivors, and disability insurance as shown by the records of the Secretary on the date of the request;

“(C) a separate estimate of the aggregate of the employee and self-employment contributions of the eligible individual for hospital insurance as shown by the records of the Secretary on the date of the request; and

“(D) an estimate of the potential monthly retirement, disability, survivor, and auxiliary benefits payable on the eligible individual’s account together with a description of the benefits payable under the medicare program of title XVIII.

“(3) For purposes of this section, the term ‘eligible individual’ means an individual who—

“(A) has a social security account number,

“(B) has attained age 25 or over, and

“(C) has wages or net earnings from self-employment.

“Notice to Eligible Individuals

“(b) The Secretary shall, to the maximum extent practicable, take such steps as are necessary to assure that eligible individuals are in-

formed of the availability of the statement described in subsection (a).

“Mandatory Provision of Statements

“(c)(1) By not later than September 30, 1995, the Secretary shall provide a statement to each eligible individual who has attained age 60 by October 1, 1994, and who is not receiving benefits under title II and for whom a current mailing address can be determined through such methods as the Secretary determines to be appropriate. In fiscal years 1995 through 1999 the Secretary shall provide a statement to each eligible individual who attains age 60 in such fiscal years and who is not receiving benefits under title II and for whom a current mailing address can be determined through such methods as the Secretary determines to be appropriate. The Secretary shall provide with each statement to an eligible individual notice that such statement is updated annually and is available upon request.

“(2) Beginning not later than October 1, 1999, the Secretary shall provide a statement on a biennial basis to each eligible individual who is not receiving benefits under title II and for whom a mailing address can be determined through such methods as the Secretary determines to be appropriate. With respect to statements provided to eligible individuals who have not attained age 50, such statements need not include estimates of monthly retirement benefits. However, if such statements provided to eligible individuals who have not attained age 50 do not include estimates of retirement benefit amounts, such statements shall include a description of the benefits (including auxiliary benefits) that are available upon retirement.”

Subtitle D—Human Resource and Income Security Provisions

SEC. 10401. INCREASE IN AUTHORIZATION FOR CHILD WELFARE SERVICES UNDER TITLE IV-B OF THE SOCIAL SECURITY ACT.

(a) IN GENERAL.—Sections 420(a), 427(b), 474(c)(4)(B), and 474(c)(4)(C) of the Social Security Act (42 U.S.C. 620(a), 627(b), 674(c)(4)(B), and 674(c)(4)(C)) are each amended by striking “\$266,000,000” and inserting “\$325,000,000”.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall take effect on October 1, 1989.

SEC. 10402. EXTENSION AND PERMANENT INCREASE IN FOSTER CARE CEILING.

(a) PERMANENT INCREASE IN APPROPRIATIONS LEVEL WHICH TRIGGERS FOSTER CARE CEILING.—Section 474(b)(2)(A) of the Social Security Act (42 U.S.C. 674(b)(2)(A)) is amended—

(1) by striking “and” at the end of clause (ii);

(2) by striking the period at the end of clause (iii) and inserting “; and”; and

(3) by adding at the end the following new clause:

“(iv) with respect to each fiscal year succeeding the fiscal year 1989, only if \$325,000,000 is appropriated under section 420 for such succeeding fiscal year.”

(b) *EFFECTIVE DATE.*—The amendments made by subsection (a) shall take effect on October 1, 1989.

SEC. 10403. MISCELLANEOUS TECHNICAL CORRECTIONS.

(a) *TECHNICAL CORRECTIONS RELATING TO THE FAMILY SUPPORT ACT OF 1988.*—

(1) *CORRECTIONS TAKING EFFECT RETROACTIVELY.*—

(A)(i) Section 407(b)(1)(B)(iii)(I) of the Social Security Act (42 U.S.C. 607(b)(1)(B)(iii)(I)), as amended by section 202(b)(8)(A), and redesignated by section 401(b)(1), of the Family Support Act of 1988, is amended by striking “409(a)(19)(C)” and inserting “402(a)(19)(C)”.

(ii) The amendment made by clause (i) shall take effect as if such amendment had been included in section 202(b)(8)(A) of the Family Support Act of 1988 on the date of the enactment of such Act.

(B)(i) Sections 402(a)(30) and 452(d)(2)(B) of the Social Security Act (42 U.S.C. 602(a)(30) and 652(d)(2)(B)) are each amended by striking “automatic” and inserting “automated”.

(ii) The amendments made by clause (i) shall take effect as if such amendments had been included in section 123(d) of the Family Support Act of 1988 on the date of the enactment of such Act.

(C)(i) Section 402(g)(1)(A) of the Social Security Act (42 U.S.C. 602(g)(1)(A)) is amended—

(I) in clause (iv), by striking “includes a child who is (or, if needy,” and inserting “received aid to families with dependent”; and

(II) in clause (v), by striking the first comma.

(ii) The amendments made by clause (i) shall take effect as if such amendments had been included in section 302(c) of the Family Support Act of 1988 on the date of the enactment of such Act.

(2) *CORRECTION TAKING EFFECT PROSPECTIVELY.*—Effective September 30, 1998, section 407(d)(1) of the Social Security Act (42 U.S.C. 607(d)(1)) is amended by striking “participated” and all that follows and inserting “participated in a program under part F”.

(b) *TECHNICAL CORRECTION RELATING TO THE TAX REFORM ACT OF 1986.*—

(1) *CORRECTION.*—Section 422(b)(1)(A) of the Social Security Act (42 U.S.C. 622(b)(1)(A)) is amended by striking “the individual or agency designated pursuant to section 2003(d)(1)(C) to administer or supervise the administration of the State’s services program” and inserting “the individual or agency that administers or supervises the administration of the State’s services program under title XX”.

(2) *EFFECTIVE DATE.*—The amendment made by paragraph (1) shall take effect as if such amendment had been included in section 1883(e)(1) of the Tax Reform Act of 1986 on the date of the enactment of such Act.

(c) *TECHNICAL CORRECTION RELATING TO SECTION 474(b)(2)(B) OF THE SOCIAL SECURITY ACT.*—

(1) **CORRECTION.**—Section 4(a)(1) of Public Law 98-617 is amended to read as follows:

“(1)(A) in paragraphs (1) and (4)(B), by striking out ‘1981 through 1984’ and inserting in lieu thereof ‘1981 through 1985’; and

“(B) in paragraph (2)(B), by striking out ‘1982 through 1984’ and inserting in lieu thereof ‘1981 through 1985’.”.

(2) **EFFECTIVE DATE.**—The amendment made by paragraph (1) of this subsection shall take effect as if included in section 4 of Public Law 98-617 at the time such section became law.

SEC. 10404. DEMONSTRATION PROJECT.

(a) **NUMBER OF PROJECTS.**—In order to determine whether, and if so, the extent to which, the use of volunteer senior aides to provide basic medical assistance and support to families with moderately or severely disabled or chronically ill children contributes to reducing the costs of care for such children, not more than 10 communities may conduct demonstration projects under this section.

(b) **DUTIES OF THE SECRETARY.**—

(1) **CONSIDERATION OF APPLICATIONS.**—The Secretary of Health and Human Services (in this section referred to as the “Secretary”) shall consider all applications received from communities desiring to conduct demonstration projects under this section.

(2) **APPROVAL OF CERTAIN APPLICATIONS.**—The Secretary shall approve not more than 10 applications to conduct projects which appear likely to contribute significantly to the achievement of the purpose of this section.

(3) **GRANTS.**—The Secretary shall make grants to each community the application of which to conduct a demonstration project under this section is approved by the Secretary to assist the community in carrying out the project.

(c) **REQUIREMENTS.**—Each community receiving a grant with respect to a demonstration project under this section shall conduct the project in accordance with such requirements as the Secretary may prescribe.

(d) **LIMITATION ON AUTHORIZATION OF APPROPRIATIONS.**—For grants under this section, there are authorized to be appropriated to the Secretary of Health and Human Services not to exceed—

(1) \$1,000,000 for each of the fiscal years 1990 and 1991; and

(2) \$2,000,000 for each of the fiscal years 1992, 1993, and 1994.

(e) **EFFECTIVE DATE.**—This section shall take effect on October 1, 1989.

SEC. 10405. AGENT ORANGE SETTLEMENT PAYMENTS EXCLUDED FROM COUNTABLE INCOME AND RESOURCES UNDER FEDERAL MEANS-TESTED PROGRAMS.

(a) **IN GENERAL.**—

(1) **TREATMENT OF PAYMENTS.**—The payments made from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the *In re Agent Orange product liability litigation*, M.D.L. No. 381 (E.D.N.Y.), shall not be considered income or resources in determining eligibility for the

amount of benefits under any Federal or federally assisted program described in paragraph (2).

(2) **PROGRAMS INVOLVED.**—The program benefits described in this paragraph are—

(A) benefits under the supplemental security income program under title XVI of the Social Security Act;

(B) aid to families with dependent children under a State plan approved under section 402(a) of the Social Security Act;

(C) medical assistance under a State plan approved under section 1902(a) of the Social Security Act;

(D) benefits under title XX of the Social Security Act;

(E) benefits under the food stamp program (as defined in section 3(h) of the Food Stamp Act of 1977);

(F) benefits under the special supplemental food program for women, infants, and children established under section 17 of the Child Nutrition Act of 1966;

(G) benefits under section 336 of the Older Americans Act;

(H) benefits under the National School Lunch Act;

(I) benefits under any housing assistance program for lower income families or elderly or handicapped persons which is administered by the Secretary of Housing and Urban Development or the Secretary of Agriculture;

(J) benefits under the Low-Income Home Energy Assistance Act of 1981;

(K) benefits under part A of the Energy Conservation in Existing Buildings Act of 1976;

(L) benefits under any educational assistance grant or loan program which is administered by the Secretary of Education; and

(M) benefits under a State plan approved under title I, X, XIV, or XVI of the Social Security Act.

(b) **EFFECTIVE DATE.**—Subsection (a) shall take effect on January 1, 1989.

SEC. 10406. TREATMENT OF TRIENNIAL REVIEWS OF STATE FOSTER CARE PROTECTIONS FOR FISCAL YEARS BEFORE OCTOBER 1, 1990.

The Secretary of Health and Human Services shall not, before October 1, 1990, reduce any payment to, withhold any payment from, or seek any repayment from, any State under part B or E of title IV of the Social Security Act, by reason of a determination made in connection with any triennial review of State compliance with the foster care protections of section 427 of such Act for any Federal fiscal year preceding fiscal year 1991.

TITLE XI—MISCELLANEOUS

SEC. 11001. SECTION 202(b) EXCEPTION.

Any transfer of outlays, receipts, or revenues from one fiscal year to an adjacent fiscal year that occurs pursuant to any provision of this Act or any amendment made by this Act shall be considered a necessary (but secondary) result of a significant policy change as

provided in section 202(b) of the Balanced Budget and Emergency Deficit Control Reaffirmation Act of 1987.

SEC. 11002. RESTORATION OF FUNDS SEQUESTERED.

(a) ORDER RESCINDED.—(1) Upon the issuance of a new final order by the President under subsection (b)(3), the order issued by the President on October 16, 1989, pursuant to section 252 of the Balanced Budget and Emergency Deficit Control Act of 1985 is rescinded.

(2) Except as otherwise provided in sections 6001, 6101, and 6201, and subject to subsection (b), any action taken to implement the order issued by the President on October 16, 1989, shall be reversed, and any sequesterable budgetary resource that has been reduced or sequestered by such order is restored, revived, or released and shall be available to the same extent and for the same purpose as if an order had not been issued.

(3) For purposes of section 702(d) and 1101(c) of the Ethics Reform Act of 1989, the order issued by the President on October 16, 1989, pursuant to section 252 of the Balanced Budget and Emergency Deficit Control Act of 1985 is deemed to be rescinded on January 31, 1990.

(b) ADJUSTED REDUCTION.—

(1) Before the close of the fifteenth calendar day beginning after the date of enactment of this Act, the Director of OMB shall issue a revised report using the exact budget baseline set forth in the report of October 16, 1989, and following the requirements, specifications, definitions, and calculations required by the Balanced Budget and Emergency Deficit Control Act of 1985 for the final report issued under section 251(c)(2) for fiscal year 1990, except that the aggregate outlay reduction to be achieved shall be an amount equal to \$16.1 billion multiplied by 130 divided by 365. Calculations made to carry out the preceding sentence shall take into account the reductions and cancellations achieved by paragraphs (2) and (3) and shall not be affected by subsection (d).

(2) Notwithstanding any provision of law other than this paragraph, the reductions and cancellations in the student loan programs described in section 256(c) of the Balanced Budget and Emergency Deficit Control Act of 1985 achieved by the order issued by the President on October 16, 1989, shall remain in effect through December 31, 1989, and no reductions or cancellations in such programs shall be made by the order issued under paragraph (4).

(3) Notwithstanding any provision of law other than this paragraph, any automatic spending increase suspended or cancelled by the order issued by the President on October 16, 1989, shall be paid at a rate that is 130/365ths less than the rate that would have been paid under the laws providing for such automatic spending increase.

(4) On the date that the Director submits a revised report to the President under paragraph (1) for fiscal year 1990, the President shall issue a new final order to make all of the reductions and cancellations specified in such report in conformity with section 252(a)(2) of the Balanced Budget and Emergency

Deficit Control Act of 1985. Such order shall be deemed to have become effective on October 16, 1989.

(c) *COMPLIANCE REPORT BY COMPTROLLER GENERAL.*—Before the close of the thirtieth day beginning after the date the President issues a new final order under subsection (b)(4), the Comptroller General shall submit to the Congress and the President a compliance report setting forth the information required under section 253 of the Balanced Budget and Emergency Deficit Control Act of 1985 with respect to such order.

(d) *NO DOUBLE REDUCTION IN MEDICARE.*—With respect to items and services described in section 6001(a), 6101, or 6201(a) for periods for which reductions are made pursuant to the respective sections, no reduction shall be made under subsection (b).

And the Senate agree to the same.

From the Committee on the Budget, for consideration of the House bill (except title XI and sections 10181 through 10191), and the Senate amendment (except title VI), and modifications committed to conference, and as exclusive conferees with respect to any proposal to report in total disagreement:

LEON E. PANETTA,
RICHARD A. GEPHARDT,
MARTY RUSSO,
MARVIN LEATH,
CHARLES E. SCHUMER,
BARBARA BOXER,
JIM SLATTERY,
BILL FRENZEL,
BILL GRADISON,
BILL GOODLING,

From the Committee on the Budget, for consideration of title XI and sections 10181 through 10191 of the House bill, and title VI of the Senate amendment, and modifications committed to conference:

LEON E. PANETTA,
RICHARD A. GEPHARDT,
MARTY RUSSO,
ED JENKINS,
FRANK GUARINI,
BILL FRENZEL,
BILL GRADISON,
WM. THOMAS,

From the Committee on Agriculture, for consideration of title I of the House bill, and title I of the Senate amendment, and modifications committed to conference:

E DE LA GARZA,
DAN GLICKMAN,
CHARLES STENHOLM,
JERRY HUCKABY,
GEORGE E. BROWN, Jr.,
GLENN ENGLISH,
GARY CONDIT,
EDWARD MADIGAN,
E. THOMAS COLEMAN,

ARLAN STANGELAND,
BILL SCHUETTE,

From the Committee on Agriculture, for consideration of subtitle B of title VI (except section 6131) of the House bill, and modifications committed to conference:

E DE LA GARZA,
JERRY HUCKABY,
JIM OLIN,
RICHARD H. STALLINGS,
CLAUDE HARRIS,
BILL SARPALIUS,
RON MARLENEE,
SID MORRISON,
ROBERT F. SMITH,

From the Committee on Banking, Finance and Urban Affairs, for consideration of title II of the House bill, and title II of the Senate amendment, and modifications committed to conference:

HENRY GONZALEZ,
FRANK ANNUNZIO,
WALTER E. FAUNTROY,
BRUCE A. MORRISON,
BEN ERDREICH,
PAUL E. KANJORSKI,
CHALMERS P. WYLIE,
DOUG BEREUTER,
BILL PAXON,

From the Committee on Education and Labor, for consideration of sections 3000 through 3009 of the House bill, and subtitle B of title VIII of the Senate amendment, and modifications committed to conference:

AUGUSTUS F. HAWKINS,
PAT WILLIAMS,
WILLIAM D. FORD,
MAJOR R. OWENS,
CHARLES A. HAYES,
CARL C. PERKINS,
TOM COLEMAN,
STEVE GUNDERSON,
PAUL HENRY,
PETER SMITH,

From the Committee on Education and Labor, for consideration of sections 3051 through 3201 and 11851 through 11894 of the House bill, and subtitle A of title VIII of the Senate amendment, and modifications committed to conference:

AUGUSTUS F. HAWKINS,
WILLIAM CLAY,
WILLIAM D. FORD,
DALE E. KILDEE,
GEO. MILLER,
CHARLES A. HAYES,
MAJOR R. OWENS,

From the Committee on Education and Labor, for consideration of subtitles D and E of title III of the House bill, and modifications committed to conference:

AUGUSTUS F. HAWKINS,
 WILLIAM D. FORD,
 GEORGE MILLER,
 DALE E. KILDEE,
 PAT WILLIAMS,
 MAJOR R. OWENS,
 TOM SAWYER,
 NITA M. LOWEY,
 TOM TAUKE,
 TOM PETRI,
 STEVE GUNDERSON,
 HARRIS W. FAWELL,
 FRED GRANDY,

From the Committee on Energy and Commerce, for consideration of subtitles A through E of title IV, subtitle B of title X (except sections 10101 through 10112, 10171, 10181, and 10182), and sections 10003, 10005 (except subsection (c)), 10077(d), 10226, 10233, and 10248 of the House bill, and sections 4001 through 4013, 5201 through 5401, 5501, and 5601 (insofar as it relates to title XIX of the Social Security Act) of the Senate amendment, and modifications committed to conference:

JOHN D. DINGELL,
 HENRY A. WAXMAN,
 JAMES H. SCHEUER,
 RON WYDEN,
 TERRY L. BRUCE,
 NORMAN F. LENT,
 EDWARD R. MADIGAN,
 BOB WHITTAKER (except for
 subtitles C and D of title IV
 and sections 10183 through
 10191, 10226, 10233, and 10248
 of the House bill, and section
 5501 of the Senate
 amendment),

Provided that Mr. Tauke is appointed in place of Mr. Danemeyer for consideration of sections 4001 and 10123 of the House bill, and Mr. Bilirakis is appointed in place of Mr. Whittaker for consideration of sections 10183 through 10191 of the House bill, and Mr. Nielson of Utah is appointed in place of Mr. Whittaker for consideration of subtitles C and D of title IV and sections 10226, 10233, and 10248 of the House bill and section 5501 of the Senate amendment:

THOMAS J. TAUKE,
 HOWARD C. NIELSON,

From the Committee on Energy and Commerce, for consideration of subtitle F of title IV and section 6001 of the House bill, and section 4101 of the Senate amendment, and modifications committed to conference:

JOHN D. DINGELL,
 PHIL SHARP,
 DOUG WALGREN,
 BILLY TAUZIN,
 JIM COOPER,
 BILL RICHARDSON,
 JOHN BRYANT,
 NORMAN F. LENT,
 CARLOS J. MOORHEAD,
 BILL DANNEMEYER,
 JACK FIELDS,

From the Committee on Energy and Commerce, for consideration of subtitles G and H of title IV of the House bill, and section 301 of the Senate amendment, and modifications committed to conference:

JOHN D. DINGELL,
 ED MARKEY,
 AL SWIFT,
 CARDISS COLLINS,
 DENNIS E. ECKART,
 RICK BOUCHER,
 THOMAS J. MANTON,
 NORMAN F. LENT,
 MATT RINALDO,
 TOM TAUKE

(except for subtitle G of title
 IV of the House bill),

THOMAS J. BLILEY, Jr. (except for
 subtitle G of title IV of the
 House bill),

From the Committee on Government Operations, for consideration of title V and section 8001 of the House bill, and section 7001 of the Senate amendment, and modifications committed to conference:

JOHN CONYERS,
 CARDISS COLLINS,
 STEVE NEAL,
 BEN ERDREICH,
 ALBERT G. BUSTAMANTE,
 GERALD D. KLECZKA,
 BARBARA BOXER,
 CHRISTOPHER SHAYS,
 PETER SMITH,
 BILL CLINGER,

From the Committee on Interior and Insular Affairs, for consideration of subtitle F of title IV and title VI of the House bill, and section 4101 of the Senate amendment, and modifications committed to conference:

MORRIS K. UDALL,
 GEO. MILLER,
 ED MARKEY,
 AUSTIN J. MURPHY,
 BRUCE F. VENTO,
 PAT WILLIAMS (except for

subtitles B and C of title VI of the House bill),

DON YOUNG,
JAMES V. HANSEN,

Provided that Mr. Sharp is appointed in place of Mr. Williams for consideration of subtitles B and C of title VI of the House bill:

PHIL SHARP,

From the Committee on Interior and Insular Affairs, for consideration of section 4201 of the Senate amendment, and modifications committed to conference:

MO UDALL,
GEORGE MILLER,
DON YOUNG,

From the Committee on Merchant Marine and Fisheries, for consideration of title VII of the House bill, and sections 302(b), 303, and 4201 of the Senate amendment, and modifications committed to conference:

WALTER B. JONES,
GERRY STUDDS,
BILL HUGHES,
BILLY TAUZIN,
TOM FOGLIETTA,
D.M. HERTEL,
ROY DYSON,
BOB DAVIS,
DON YOUNG,

From the Committee on Post Office and Civil Service, for consideration of titles V and VIII and sections 10004(a) and 10004(b) of the House bill, and title VII of the Senate amendment, and modifications committed to conference:

WILLIAM D. FORD,
WILLIAM CLAY,
PAT SCHROEDER,
MARY ROSE OAKAR,
GERRY SIKORSKI,
FRANK MCCLOSKEY,
GARY L. ACKERMAN,
BEN GILMAN,
FRANK HORTON,
DON YOUNG,
TOM RIDGE,

From the Committee on Public Works and Transportation, for consideration of sections 302(a), 304, and 4301 of the Senate amendment, and modifications committed to conference:

GLENN M. ANDERSON,
ROBERT A. ROE,
NORMAN Y. MINETA,
JAMES L. OBERSTAR,
HENRY J. NOWAK,
DOUG APPELEGATE,
JOHN PAUL HAMMERSCHMIDT,
BUD SHUSTER,

ARLAN STANGELAND,
BILL CLINGER,

From the Committee on Veterans' Affairs, for consideration of title IX and section 11650 (except subsection (a)) of the House bill, and title IX of the Senate amendment, and modifications committed to conference:

G.V. MONTGOMERY,
DON EDWARDS,
DOUG APPLGATE,
LANE EVANS,
TIMOTHY J. PENNY,
HARLEY O. STAGGERS, Jr.,
J. ROY ROWLAND,
BOB STUMP,
JOHN PAUL HAMMERSCHMIDT,
CHALMERS P. WYLIE,
BOB McEWEN,

From the Committee on Ways and Means, for consideration of subtitle B of title III and title XI (except sections 11901 through 11903) of the House bill, and the third item listed under miscellaneous charges in the fee schedules set forth in section 301(a)(1), title VI, and sections 302, 4004 through 4013, and 8001 of the Senate amendment, and modifications committed to conference:

DAN ROSTENKOWSKI,
SAM M. GIBBONS,
J.J. PICKLE,
CHARLES B. RANGEL,
PETE STARK,
HAROLD FORD,
TOM DOWNEY,
GUY VANDER JAGT,
RICHARD T. SCHULZE,

From the Committee on Ways and Means, for consideration of subtitle A of title IV, sections 4101 (insofar as it relates to section 1142 of the Social Security Act), 4111, and 4121 (insofar as it relates to section 1142 of the Social Security Act), and title X (except sections 10181 through 10191) of the House bill, and title V (except section 5501) of the Senate amendment, and modifications committed to conference:

DAN ROSTENKOWSKI,
SAM M. GIBBONS,
J.J. PICKLE,
CHARLES B. RANGEL,
PETE STARK,
ANDREW JACOBS, Jr.,
TOM DOWNEY,

From the Committee on Ways and Means, for consideration of sections 10181 through 10191 of the House bill, and modifications committed to conference:

DAN ROSTENKOWSKI,
PETE STARK,
BRIAN DONNELLY,

WILLIAM J. COYNE,
J.J. PICKLE,
JIM ARCHER,
GUY VANDER JAGT,

From the Committee on Ways and Means, for consideration of sections 11901 through 11903 of the House bill, and modifications committed to conference:

DAN ROSTENKOWSKI,
TOM DOWNEY,
HAROLD FORD,
ROBERT T. MATSUI,
BARBARA KENNELLY,
MICHAEL ANDREWS,
RICHARD T. SCHULZE,
E. CLAY SHAW,

From the Committee on Ways and Means, for consideration of section 304 of the Senate amendment, and modifications committed to conference:

DAN ROSTENKOWSKI,
TOM DOWNEY,
RAY McGRATH,

Managers on the Part of the House.

From the Committee on the Budget:

JIM SASSER,
DON RIEGLE,
FRANK R. LAUTENBERG,
PAUL SIMON,
TERRY SANFORD,
WYCHE FOWLER, Jr.,
CHRISTOPHER DODD,
PETE DOMENICI,
CHUCK GRASSLEY,
BOB KASTEN,

From the Committee on Agriculture, Nutrition, and Forestry:

PATRICK LEAHY,
DAVID PRYOR,
DAVID L. BOREN,
RICHARD G. LUGAR,
BOB DOLE,

From the Committee on Armed Services:

SAM NUNN,
J.J. EXON,
JOHN WARNER,

From the Committee on Banking, Housing, and Urban Affairs:

DON RIEGLE,
ALAN CRANSTON,
PAUL SARBANES,
CHRIS DODD,
JIM SASSER,
ALFONSE D'AMATO,
PHIL GRAMM,

From the Committee on Commerce, Science, and Transportation:

DANIEL K. INOUE,
WENDELL H. FORD,

From the Committee on Energy and Natural Resources:

J. BENNETT JOHNSTON,
DALE BUMPERS,
BILL BRADLEY,
TIMOTHY E. WIRTH,
JAMES A. MCCLURE,
MALCOLM WALLOP,
FRANK H. MURKOWSKI,

From the Committee on Environment and Public Works:

QUENTIN N. BURDICK,
DANIEL PATRICK MOYNIHAN,
MAX BAUCUS,
JOHN BREAUX,
ALAN K. SIMPSON,
DAVE DURENBERGER,

From the Committee on Finance:

LLOYD BENTSEN,
SPARK MATSUNAGA,
DANIEL PATRICK MOYNIHAN,
MAX BAUCUS,
GEORGE MILLER,
DON RIEGLE,
JOHN D. ROCKEFELLER,
BOB PACKWOOD,
BOB DOLE,
JOHN DANFORTH,
JOHN H. CHAFEE,
JOHN HEINZ,

From the Committee on Governmental Affairs:

JOHN GLENN,
DAVID PRYOR,
JIM SASSER,
TED STEVENS,

From the Committee on Labor and Human Resources:

EDWARD M. KENNEDY,
CLAIBORNE PELL,
HOWARD M. METZENBAUM,
ORRIN G. HATCH,
NANCY LANDON KASSEBAUM,

From the Committee on Veterans' Affairs:

ALAN CRANSTON,
SPARK MATSUNAGA,
FRANK H. MURKOWSKI,

Managers on the Part of the Senate.

fee for the original guaranteed loan secured by the same property securing the vendee loan sold; (b) the crediting be made without reduction and for the fiscal year in which the amount involved was received; and (c) all amounts so credited offset outlays of the respective fund during the fiscal year in question.

Senate amendment

No provision.

Conference agreement

Section 5003 follows the House bill by providing that, notwithstanding any other provision of law (such as Public Laws 93-344 and 100-119), (a) the proceeds of with-recourse sales be credited as offsetting collections of the LGRF or a subsequently established revolving fund when it receives the fee for the original guaranteed loan; (b) the crediting be made without reduction and for the fiscal year in which the proceeds were received; and (c) all amounts so credited for a fiscal year offset outlays of such revolving fund during that fiscal year.

TITLE VI—MEDICARE, MEDICAID, AND MATERNAL AND CHILD HEALTH, AND OTHER HEALTH PROVISIONS

SUBTITLE B—MEDICAID

1. Infant Mortality Provisions

Sections 4201 through 4206 of the House bill.

(A) PHASED-IN COVERAGE OF PREGNANT WOMEN AND INFANTS UP TO 185 PERCENT OF POVERTY LEVEL

(1) In general

Present law

MCCA requires States to offer Medicaid coverage to pregnant women and infants under one year old with family incomes below 75 percent of the Federal poverty line by July 1, 1989, and to those with family incomes below 100 percent of the poverty line by July 1, 1990. OBRA (1987) permits States to establish a higher income standard for pregnant women and infants, up to 185 percent of the poverty line.

House bill (section 4201)

Requires States to offer Medicaid coverage to pregnant women and infants with family incomes up to 130 percent of the poverty line by April 1, 1990; up to 150 percent of the poverty line by July 1, 1992; and up to 185 percent of the poverty line by July 1, 1993. Provides that a State that, as of the date of enactment, has already opted for an income standard higher than 130 percent, or has authorized or appropriated funds in anticipation of adopting such a standard, must continue to use the higher standard after April 1, 1990. Applies to payments for calendar quarters beginning on or after April 1, 1990, regardless of whether implementing regulations have been promulgated by that date.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House bill, with a modification requiring all States (including Arizona) to cover pregnant women and infants with family incomes of up to 133 percent of the Federal poverty level.

The conferees wish to underscore the contribution made by the late Representative Mickey Leland (D-Texas) to the inclusion of this provision (and the related Medicaid child health amendments) in the conference agreement. As the primary sponsor of the Medicaid Infant Mortality Amendments of 1989, H.R. 800, from which the conference agreement is derived, Mickey Leland was unrelenting in his efforts to lower this Nation's infant mortality rate and give those of its children born in poverty a healthy start in life. For the welfare of these children, and in his memory, the conferees agree to this provision and urge its enactment.

The conference agreement contains an additional modification directing the Secretary to enter into agreements with several States to conduct demonstrations of alternatives for extending Medicaid coverage, or alternative coverage, to pregnant women and children under age 20 who are otherwise ineligible for Medicaid and whose family incomes are below 185 percent of the Federal poverty level. Alternative coverage may include, but is not limited to, such options as enrollment under employer plans, the State's plan for its own employees, a State uninsured plan, or an HMO. If a project includes enrollment under employer plans, it must require an employer contribution. Projects must provide for premiums to be charged to families with incomes above 100 percent of the poverty level. The premium must be equal to the lesser of a sliding scale or 3 percent of family income. Demonstrations are to be conducted for not longer than 3 years. The Secretary is authorized to waive the requirement that State Medicaid plans operate uniformly throughout the State. Federal Medicaid matching funds participation in the projects is limited to \$10 million per year in each of FY 1990, FY 1991, and FY 1992. Costs of services are to be matched at each State's regular Federal matching rate for services, and costs for administrative expenses are to be matched at the rate appropriate to the administrative function. The Secretary is required to submit an interim evaluation of the projects to Congress by January 1, 1991, and a final report by January 1, 1994.

(2) Flexibility in income methodology and deduction of child care in computation of income

Present law

In determining family income for pregnant women and infants with family incomes below the Federal poverty level, a State must use the same methodology used in its Aid to Families with Dependent Children (AFDC) program, except that it may not deem as available to the applicant income of relatives other than a spouse

or parent, and may not subtract from income costs for medical care.

House bill

Provides that a State may adopt a less restrictive income methodology for pregnant women and infants than that used in determining eligibility for AFDC. Requires that States exclude from income the costs of child care necessary for the employment of the pregnant woman or the infant's caretaker.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill.

(3) Prohibiting application of resource test

Present law

In determining eligibility for pregnant women and infants, a State may impose a resource standard; that is, a limit on allowable assets. For pregnant women, this standard must be no more restrictive than that used in determining eligibility for Supplemental Security Income (SSI). For infants and children, it must be no more restrictive than that used for AFDC.

House bill

Prohibits the use of any resource standard or methodology in determining eligibility for pregnant women and infants.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill.

(4) Report and transition on errors in eligibility determinations

Present law

States are required to maintain a Medicaid quality control system, which identifies Medicaid payments made as a result of erroneous eligibility determinations. If a State's error rate (erroneous Medicaid payments as a percent of total Medicaid payments) exceeds 3 percent, it may be subject to a reduction in Federal matching funds.

House bill

Requires the Secretary to report to Congress by July 1, 1990, on State error rates in determining eligibility for pregnant women and infants. Provides that the calculation of State error rates and financial penalties is to exclude Medicaid payments made on behalf of pregnant women and infants on or after July 1, 1989, and before the first calendar quarter beginning more than 12 months after the Secretary submits the required report.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill.

(B) PRESUMPTIVE ELIGIBILITY

Present law

(1) *Extension of presumptive eligibility period.*—States have the option of establishing “presumptive eligibility” for low-income pregnant women. Certain providers may make a preliminary determination that a pregnant woman seeking treatment is potentially eligible for Medicaid. The woman may then receive services related to the pregnancy for up to 45 days, or until the State completes an eligibility review, whichever is earlier. If a woman who has been determined by a provider to be presumptively eligible for Medicaid services fails to apply for Medicaid within 14 days after the determination is made, presumptive eligibility ceases.

(2) *Flexibility in application.*—States design their own application forms for Medicaid benefits. In the case of pregnant women, some States may use different forms for the presumptive eligibility determination and the final eligibility determination, while others may use the same form for both. Current law has no provision on this subject.

House bill (section 4202)

(1) *Extension of presumptive eligibility period.*—Extends the time limit for filing a Medicaid application to the last day of the month following the month in which the provider makes an initial determination of presumptive eligibility, and continues eligibility to that date in the case of a woman who fails to apply. In the case of a woman who applies within the time limit, continues presumptive eligibility until the date the State completes its eligibility determination.

(2) *Flexibility in application.*—Provides that the Medicaid application form to be filed by women who have been determined presumptively eligible may be the form used by the State for applications by women potentially eligible solely because of pregnancy.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill.

(C) OPTIONAL COVERAGE OF PRENATAL AND POSTPARTUM HOME VISITATION SERVICES

Present law

No provision.

House bill (section 4203)

Provides that States may cover as an optional Medicaid service home visitation services, as prescribed by a physician, to high-risk pregnant women and/or to high-risk infants under 1 year old. Effective July 1, 1990.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill.

(D) PAYMENT FOR OBSTETRICAL AND PEDIATRIC SERVICES*Present law*

States establish their own payment levels for Medicaid services. Medicaid regulations (42 C.F.R. 447.204) provide that payments must be sufficient to enlist enough providers so that covered services will be available to Medicaid beneficiaries to at least the extent that such services are available to the general population.

House bill (section 4204)

(1) Codification and enforcement of adequate payment level provisions.—Incorporates the regulatory provision in the Medicaid statute, with the additional specification that the test of comparative availability of services may be applied to specific geographic areas. Provides that a State Medicaid plan will not be considered to meet this requirement unless, by April 1 of 1990 and each succeeding year, the State submits an amendment to the plan specifying the payment rates for non-institutional obstetrical and pediatric services to be effective during the period beginning July 1 of that year. The amendment must include data on how these payment rates are taken into account in developing the payment rates for HMOs with Medicaid contracts, along with additional data that will assist the Secretary in evaluating the State's compliance with the minimum payment requirement. Requires the Secretary to review and approve or disapprove the amendment within 90 days; in the event of disapproval, the State must immediately submit a revised amendment that complies with the payment requirement.

Provides that, beginning in 1992, data submitted by the State with the amendment must include information on average Medicaid payments, by procedure, for obstetrical and pediatric services during the second previous year; requires that information be provided separately for providers in each metropolitan statistical area (or similar area) in the State and for the remainder of the State. Further provides that no provision of Medicaid law shall be construed as prohibiting a State from making higher payments for obstetrical and pediatric services in rural areas than in urban ones.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House bill, with an additional modification: effective July 1, 1990, States are required to cover under their Medicaid programs services of certified pediatric or family nurse practitioners practicing with the scope of State law, regardless of whether they are under the supervision of, or associated with, a physician or other provider. This requirement is effective July 1, 1990.

*(2) Payment for certain services in certain federally-funded health centers**Present law*

States are permitted, but not required, to cover services in community and migrant health centers and providers of health care to the homeless receiving Federal grants under the Public Health Service Act. States that cover such services establish their own reimbursement methodologies.

House bill (section 4204)

Requires States to cover ambulatory services to pregnant women and children under age 18 in Federally-funded community and migrant health centers and providers of health care to the homeless. Provides that payment for such services must be equal to 100 percent of the facilities' reasonable costs for providing the services; reasonableness may be subject to tests developed by the Secretary for Medicare purposes or specifically for Medicaid. Effective July 1, 1990, regardless of whether implementing regulations have been promulgated.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill with a modification requiring States to include in their Medicaid benefit package Federally-qualified health center services and any other ambulatory services offered by a Federally-qualified health center and which are otherwise included in the plan. These services would be available to all program beneficiaries, not just pregnant women and children. Federally-qualified health centers are facilities which (1) are receiving grants under section 329, 330, or 340 of the Public Health Service Act, or (2) are determined by the Secretary (based on the recommendation of the Health Resources and Services Administrator within the Public Health Service) to meet the requirements for receiving such a grant (subject to a waiver for up to 2 years for good cause shown). This requirement is effective April 1, 1990, without regard to whether or not final regulations to carry out such amendments have been promulgated.

(E) ROLE IN PATERNITY DETERMINATIONS

Present law

Applicants for Medicaid are required, as a condition of eligibility, to cooperate in establishing the paternity of children born out of wedlock and in obtaining child support, unless there is good cause for non-cooperation.

House bill (section 4205)

Exempts women qualifying only for Medicaid coverage under the special eligibility standards for pregnant women from the requirement that they cooperate in establishing paternity and obtaining child support. Effective on enactment

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill.

(F) REQUIRED MEDICAID NOTICE AND COORDINATION WITH SPECIAL SUPPLEMENTAL FOOD PROGRAM FOR WOMEN, INFANTS, AND CHILDREN (WIC)

Present law

The WIC program provides supplemental food to certain low-income mothers and young children, along with nutritional counseling and some health-related services. Although many persons qualifying for WIC are also eligible for Medicaid, there is currently no coordination between the two programs.

House bill (section 4206)

Requires State Medicaid plans to provide for coordination between the Medicaid and WIC programs. Requires the State to notify Medicaid beneficiaries who are pregnant, post partum or breastfeeding women, or children under age 5, of the availability of WIC benefits and to refer such persons to the State agency administering the WIC program. Effective July 1, 1990.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House bill.

2. Child Health Amendments

Sections 4211-4217 of House bill.

(A) PHASED-IN MANDATORY COVERAGE OF CHILDREN UP TO 100 PERCENT OF POVERTY LEVEL

Present law

(1) *In general.*—States are permitted to cover children who are over 1 year old and less than 2, 3, 4, 5, 6, 7, or 8 years old (at the

State's option), in families with incomes below a State-established income level which may be as high as 100 percent of the Federal poverty level. In determining family income for these children, a State must use the same methodology used in its AFDC program, except that it may not deem as available to the applicant income of relatives other than a spouse or parent, and may not subtract from income costs for medical care. A State may impose a resource standard that is no more restrictive than that used in determining eligibility for AFDC.

(2) *Applications using outreach locations.*—States determine the sites at which applications for Medicaid will be accepted. For persons applying for Medicaid only, and not for cash assistance, a State may use the same application form used for the cash assistance programs or may develop a different form.

House bill (section 4211)

(1) *In general.*—Requires States to cover children born after September 30, 1983, who are over 1 year old but under 18 years old, with family incomes up to 100 percent of the Federal poverty level. Prohibits the use of a resource standard for these children, and permits the State to adopt an income methodology less restrictive than that used for AFDC. Requires that States exclude from income the costs of child care necessary for the employment of the child's caretaker. Provides that a State that operates a medical assistance program for low-income persons under a Federal demonstration waiver in lieu of Medicaid (as Arizona now does) must comply with the new requirements at the same time as other States. Applies to payments for calendar quarters beginning on or after July 1, 1990, regardless of whether implementing regulations have been promulgated by that date. Delay is permitted where State legislation is required to comply. Texas is not required to comply with the new requirements until September 1, 1991.

(2) *Applications using outreach locations.*—Requires States to accept applications by pregnant women and children under 18 at sites other than those used for AFDC applications. Alternate sites could include hospitals or clinics. If health facilities are used, the State is prohibited from discriminating between public and private facilities. Requires the State to use an application form different from the AFDC form for pregnant women and children under 18 applying for Medicaid only. Effective July 1, 1990.

Senate amendment

No provision.

Conference agreement

(1) *In general.*—The conference agreement follows the House bill with the following modifications: (1) States are required to extend Medicaid coverage to all children born after September 30, 1990, up to age 6, in families with incomes below 133 percent of the Federal poverty level; and (2) the requirement is effective April 1, 1990, in all States (including Arizona).

(2) *Applications using outreach locations.*—The conference agreement does not include the House bill.

(B) EXTENSION OF MEDICAID TRANSITION COVERAGE

Present law

(1) Effective April 1, 1990, States will be required to continue Medicaid benefits for 6 months after a family loses AFDC benefits because of increased earnings or hours of employment, if the family received AFDC benefits in 3 of the 6 months preceding the termination. The State must also offer an additional 6 months of coverage when the initial 6-month period ends; the State may require that the family pay a premium for coverage in this second period, may limit benefits to acute care, and may substitute enrollment in an alternative insurance plan for standard Medicaid coverage. These new transition coverage provisions, added by the Family Support Act of 1988 (P.L. 100-485), expire September 30, 1998.

(2) Transitional Medicaid coverage is subject to early termination if the family no longer includes a child who meets (or would meet if needy) the AFDC definition of dependency.

(3) Before enactment of the Family Support Act, States were required to continue Medicaid for 6 months for families losing AFDC because they ceased to qualify for income disregards, temporary exclusions of earned income from the total income used in determining AFDC eligibility. A State could, at its option, provide up to 9 months of additional coverage after the initial 6 months, for a total of 15 months. The Family Support Act suspended this provision for families losing AFDC between April 1, 1990, and September 30, 1998; these families will instead receive the 12-month transition coverage established by the Act.

House bill (section 4212)

(1) Permits a State to offer up to one full year of additional coverage, beyond the year provided by the Family Support Act; coverage in the optional second year is subject to the same rules as coverage in the last 6 months of the mandatory first year. Makes the new transition coverage provisions added by the Family Support Act permanent. Effective April 1, 1990.

(2) Provides that coverage is not subject to early termination if the family still includes a child, whether or not the child meets the AFDC definition of dependency. Effective April 1, 1990.

(3) Provides that the suspension of the 6-month/9-month extension does not apply to families that lose AFDC eligibility before April 1, 1990 (and who may therefore be in the middle of a 15-month extension at the time the 12-month provision takes effect). Effective as if included in the Family Support Act of 1988.

Senate amendment

No provision.

Conference agreement

The conference agreement includes items (2) and (3) of the House bill.

(C) EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT
SERVICES DEFINED

Present law

States are required to cover early and periodic screening, diagnostic, and treatment (EPSDT) services for most groups of Medicaid beneficiaries under age 21. Medicaid regulations provide the EPSDT screenings must include a health and developmental history, a comprehensive physical exam, vision and hearing testing, appropriate laboratory tests, and dental screening for children over 3 years old (or over 5 years old, with the Secretary's approval). The regulations require that States establish, in consultation with medical and dental organizations, a "periodicity schedule" for screenings, specifying services applicable at each stage of the beneficiary's life. States must also provide treatment for problems or conditions identified during screening. The regulations provide that, in addition to any treatment services normally covered under the State Medicaid plan, the State must provide dental care, appropriate immunizations, and vision and hearing treatment, including eyeglasses and hearing aids.

House bill (section 4213)

Codifies the current regulations on minimum components of EPSDT screening and treatment, with minor changes. Provides that screenings must include blood testing when appropriate, as well as health education. Eliminates the option of delaying dental screening to age 5. Requires distinct periodicity schedules for screening, vision, dental, and hearing services, and provides that services be furnished at intervals other than those specified in the periodicity schedule when medically necessary to identify and treat a suspected illness or condition. Provides that nothing in Medicaid law should be construed as limiting EPSDT providers to those that can furnish all the required EPSDT services or preventing providers qualified to furnish only a part of the EPSDT package from participating in the program. Requires States to report annually to the Secretary, by April 1 after the end of each fiscal year (beginning with FY 90), on the number of children receiving EPSDT screens, the number referred for follow-up treatment, and the number receiving dental services, by age and basis of Medicaid eligibility. Effective on enactment.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill with the following modifications: (1) States are required to provide any service that a State is allowed to cover with Federal matching funds under Medicaid that is required to treat a condition identified during a screen, whether or not the service is included in the State's Medicaid plan; (2) the Secretary is required to develop, by July 1, 1990, and every 12 months thereafter, EPSDT participation goals for each State, and States are required to include data on the extent to

which they comply with these goals in their annual reports to the Secretary; and (3) the provision is effective April 1, 1990.

(D) EXTENSION OF PAYMENT PROVISIONS FOR MEDICALLY NECESSARY SERVICES TO CHILDREN IN DISPROPORTIONATE SHARE HOSPITALS

Present law

(1) States may establish reasonable durational limits on coverage of inpatient hospital services, but may not impose these limits on medically necessary services provided to children under 1 year old in hospitals serving a disproportionate number of low-income patients with special needs.

(2) If the State pays for inpatient services on a prospective basis (under which payment rates are established in advance and may not reflect the hospital's actual costs for covered services), the State must provide additional payment to disproportionate share hospitals for patients under 1 year old who are "outliers," that is, who incur exceptionally high costs or have long hospital stays.

House bill (section 4214)

(1) Requires States to waive durational limits for medically necessary inpatient services provided by disproportionate share hospitals to children under age 18. Applies to payments for calendar quarters beginning on or after July 1, 1990.

(2) Requires States with prospective payment systems to submit to the Secretary, by April 1, 1990, a State plan amendment providing for payment adjustments for services provided by disproportionate share hospitals after July 1, 1990, to children over age 1 but under age 18 who are outlier cases.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill.

(E) REQUIRING "SECTION 209 (B)" STATES TO PROVIDE MEDICAL ASSISTANCE TO DISABLED CHILDREN RECEIVING SSI BENEFITS

Present law

States are ordinarily required to provide Medicaid to any aged, blind, or disabled person receiving cash assistance under the Supplementary Security Income (SSI) program. However, section 209(b) of the Social Security Amendments of 1972 (P.L. 92-603) provided that a State could use more restrictive eligibility standards for Medicaid than those used for SSI if the State was using those standards for Medicaid on January 1, 1972.

House bill (section 4215)

Requires all States to provide Medicaid to persons under 18 who are receiving SSI benefits. Effective July 1, 1990.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill.

(F) MANDATORY CONTINUATION OF COVERAGE FOR CHILDREN

Present law

An individual who ceases to qualify for Medicaid benefits on one basis may still qualify on some other basis. For example, a family that is no longer financially eligible for AFDC (and hence for automatic Medicaid benefits) might still be eligible for Medicaid under a higher income standard used for the "medically needy." Under current law, States are not required, when terminating Medicaid eligibility in such a case, to determine whether the beneficiary might qualify for benefits on some other basis. Instead, the individual may be required to re-apply for Medicaid benefits.

House bill (section 4216)

Requires States, before terminating Medicaid benefits for any child under age 18, to determine that the child does not qualify for Medicaid on any other basis. Provides that the calculation of State error rates and financial penalties under the Medicaid quality control system for quarters beginning on or after July 1, 1990, is to exclude Medicaid payments made on behalf of children who have been determined ineligible on one basis but for whom the determination of potential eligibility on other bases has not been completed. Applies to eligibility determinations on or after July 1, 1990, regardless of whether implementing regulations have been promulgated by that date.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill.

(G) OPTIONAL MEDICAID COVERAGE FOR FOSTER CHILDREN

Present law

A State may provide Medicaid to a child in foster care or a group home, but only if the child's family meets the income and resource standards for Medicaid eligibility, which are generally tied to AFDC standards and are below 100 percent of the poverty level.

House bill (section 4217)

Provides that a State may offer Medicaid coverage to a child under 18 who is wholly or partially financially supported by a public agency, who resides in a foster home, group home, or private institution, and whose income does not exceed 100 percent of the Federal poverty level for a family of one. Provides that, if a State elects to cover such children, it may not impose a resource standard and must determine income using a method no more restrictive than that used under the State's plan for foster care and adoption assistance.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill.

3. Community and Facility Habilitation Services Amendments

Sections 4220-4248 of House bill.

(A) COMMUNITY HABILITATION AND SUPPORTIVE SERVICES*Present law*

(1) *Provision as optional statewide service.*—Medicaid law provides only limited coverage for home and community-based care for persons with mental retardation or related conditions: (1) under the 1915(c) waiver, States may cover habilitation and other community-based services, on a budget neutral basis, to persons at risk of institutionalization; (2) under the case management option, States may target case management services in designated areas; (3) some States use certain optional services, such as “other rehabilitative services” and “personal care services” as a means of offering certain home and community-based services to this population.

(2) *Definition of “community habilitation and supportive services”.*—There is no present law definition comparable to “community habilitation and supportive services.” However, the Medicaid 1915(c) waiver defines “habilitation services” as services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings, and includes prevocational, educational, and supported employment services. The term “habilitation services” does not include special education and related services and vocational rehabilitation services otherwise available under other Federal programs.

(3) *Individual with mental retardation or a related condition.*—Persons with mental retardation qualify for Medicaid on the basis of being disabled under the Federal Supplemental Security Income program (except in certain States using more restrictive standards), and meeting Medicaid income and resource eligibility standards. Persons with conditions related to mental retardation are defined in regulation as individuals who have a severe, chronic disability that is attributable to cerebral palsy, epilepsy, or any other condition, other than mental illness, found to be closely related to mental retardation. The condition must result in impairment of general intellectual functioning or adaptive behavior similar to that of persons with mental retardation and must require treatment or services similar to those needed by such persons. The condition must be manifest prior to age 22, be likely to continue indefinitely, and result in substantial functional limitations.

(4) *Maintenance of effort.*—No provision.

(5) *Freedom of choice.*—States must allow beneficiaries of Medicaid services freedom to choose their providers of care. However, the Secretary may waive this requirement under certain specified circumstances.

(6) *Federal minimum requirements.*—The Medicaid statute contains a general requirement that a State's plan include a description of methods and standards used to assure that services are of high quality. In general, the Medicaid program allows States to follow their own procedures for certifying noninstitutional providers of care. For the 1915(c) waiver program, States are required to provide assurances that necessary safeguards (including adequate standards for provider participation) have been taken to protect the health and welfare of individuals provided services.

(7) *State quality assurance program.*—Under their 1915(c) waivers, States must provide assurances that necessary safeguards (including adequate standards for provider participation) have been taken to protect the health and welfare of individuals provided services. For other noninstitutional providers of Medicaid covered services, States generally follow their own procedures for certifying that providers deliver quality care. Ordinarily the State Medicaid agency relies on findings of the applicable licensing agency or board for the particular provider.

(8) *Survey and certification.*—No provision.

(9) *Enforcement process.*—No provision.

(10) *Secretarial responsibilities.*—No provision.

House bill (sections 4221-4224)

(1) *Provision as optional, statewide service.*—Establishes "community habilitation and supportive services" as a new optional service that States may cover under their Medicaid plans. The service is limited to individuals with mental retardation or a related condition, regardless of whether they have been discharged from an institution.

(2) *Definition of "community habilitation and supportive services".*—Defines "community habilitation and supportive services" to mean services designed to assist individuals in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to function successfully in a home or community-based setting, or to assist individuals in participating in community or other activities. States choosing to cover the new optional service are required to include case management services, respite care services, and personal attendant care. States may also include prevocational services, education services, supported employment services, day habilitation and related services, transportation, assistive technologies, and other supportive services needed to achieve independence, productivity and integration into the community. The term does not include: special education and related services otherwise available under the Education of the Handicapped Act; vocational rehabilitation services otherwise available under the Rehabilitation Act; room and board (other than those used in the provision of covered services); and payments to members of the beneficiary's family.

(3) *Individual with mental retardation or a related condition.*—Establishes in statute the current regulatory definition of persons with conditions related to mental retardation.

(4) *Maintenance of effort.*—Requires States that elect to cover this optional benefit to report to the Secretary the amount of non-Federal funds obligated by the State (and its localities) for commu-

nity habilitation and supportive services in FY 1989. (Waiver services not required to be included.) In reporting non-Federal amounts expended for such services in subsequent years, the FY 1989 amount would be subtracted. The difference would be subject to FFP.

(5) *Freedom of choice*.—Provides that amendments are not to be construed to allow States to abrogate the beneficiary's freedom of choice in the provision of community habilitation and supportive services.

(6) *Federal minimum requirements*.—Establishes minimum Federal requirements for community habilitation and supportive services and for residential settings in which those services are provided. Specifies that minimum Federal requirements are to be set forth in regulation by the Secretary. Federal requirements are limited to those needed for the protection of the health, and welfare of clients.

For States providing habilitation and supportive services under a section 1115 waiver, requires the State to meet Federal minimum requirements as if it has elected to cover community services as an optional benefit. Federal minimum requirements do not apply to 1915(c) waivers in effect before July 1, 1990, until the date of the next renewal or, if later, the end of the 30-day period beginning on the date the Secretary promulgates interim regulations.

Specifies that community habilitation and supportive services must: (1) be aimed at expanding opportunities for independence, productivity, and community integration; (2) be provided in accordance with an individual habilitation plan based on a comprehensive assessment of the beneficiary's needs; (3) meet minimum Federal requirements governing personnel qualifications, fair compensation for care givers, and client rights.

Requirements for residential settings are related to client rights, administration, life safety, disclosure of ownership, and other matters. Client rights include: (1) freedom from physical, verbal, sexual abuse, corporal or psychological punishment, aversive stimuli, and involuntary seclusion (except time-out periods of less than one hour); (2) freedom from physical or medical restraints used for discipline or staff convenience; (3) privacy; (4) confidentiality; (5) dignity; (6) voicing of grievances; (7) free choice regarding medical care and treatment; (8) appropriate use of psychopharmacologic drugs. Requirements for residential settings do not apply to settings in which fewer than 3 unrelated adults reside, such as a client's home.

(7) *State quality assurance program*.—Requires States to establish a program for assuring the quality of community habilitation and supportive services and for protecting the rights of clients receiving these services. The quality assurance program must include publication of standards for services and client rights, periodic monitoring, enforcement of standards, public participation, and educational programs regarding quality standards. The State program does not authorize Secretarial approval if the program, on its face, meets the above requirements. No Federal Medicaid payments can be made for the State quality assurance program.

(8) *Survey and certification*.—States would be responsible for certifying compliance of providers, and of residential settings, with

Federal minimum requirements, at least once every 12 months. State certification of residential settings would be done through unannounced surveys based on a Federal protocol, and would be subject to Federal "look behind" surveys of a sample of settings in each State. State certification of providers must be based on a periodic review of a provider's performance. In the case of State providers or State residential settings, the Secretary would have exclusive survey and certification responsibility.

(9) *Enforcement process.*—Requires States to establish the following remedies for non-compliance with Federal residential standards: (1) denial of Medicaid payments for all new clients; (2) civil money penalties; (3) appointment of temporary management; and (4) emergency authority to close a facility or transfer clients. Grants the Secretary independent authority to impose civil monetary penalties and, in the case of residential facilities, appoint temporary management. Where noncompliance immediately jeopardizes the health and safety of participants, the State (or the Secretary) would be required to correct the deficiency and/or terminate the Medicaid participation of the provider. Where noncompliance does not jeopardize client health or safety, the State (or the Secretary) could apply any of the remedies listed above, but at a minimum would be required to impose a civil money penalty for each day of noncompliance.

(10) *Secretarial responsibilities.*—Requires the Secretary to issue interim regulations governing the above minimum requirements by July 1, 1990. Requires this rule to assure that persons receiving community habilitation and supportive services are protected from neglect, physical and sexual abuse, and financial exploitation. Requires final regulations by October 1, 1991. After October 1, 1991, prohibits Federal Medicaid matching payments where provider or residential setting does not meet minimum requirements. Limits Federal regulations to the protection of the health, safety, and welfare of clients receiving community services.

Authorizes the Secretary to provide technical assistance for the implementation of quality assurance requirements, including the development and operation of State quality assurance programs. Requires the Secretary to report to Congress annually regarding the extent to which providers of community habilitation and supportive services and residential settings in which such services are provided are complying with quality assurance standards. Requires the Secretary to report to Congress by January 1, 1992, regarding the use of outcome-oriented instruments to evaluate and assure the quality of community services.

Effective July 1, 1990 (except as otherwise noted) without regard to whether final regulations have been promulgated. No payment may be made after October 1, 1991, if minimum requirements are not met.

Senate amendment

No provision.

Conference agreement

The conference agreement does not contain the House bill.

(B) QUALITY ASSURANCE FOR HABILITATION FACILITY SERVICES

Present law

(1) *Definition of "habilitation facility".*—The term "habilitation facility" is not used in statute. However, the term "intermediate care facility for the mentally retarded" (ICF/MR) means an institution, or part thereof, for the mentally retarded or persons with related conditions, the primary purpose of which is to provide health or rehabilitative services. Active treatment must be provided. ICFs/MR must meet standards prescribed by the Secretary.

(2) *Requirements related to provision of services in habilitation facilities.*—Requirements relating to care in ICFs/MR are specified in regulations that establish "conditions of participation" focused on governing body and management, client protections, facility staffing, active treatment services, client behavior and facility practices, health care services, physical environment, and dietetic services. Each condition of participation is composed of a number of standards by which quality can be assessed. All conditions of participation must be met, but institutions will not be decertified if some of the standards within those conditions are not met, if a plan of correction is accepted by the Secretary.

(3) *Requirements related to client's rights in habilitation facilities.*—Current regulations specify conditions of participation regarding client protections and enumerate standards in areas of client rights; client finances; communication with clients, parents, and guardians; and staff treatment of clients.

(4) *Requirements relating to administration and other matters.*—Current regulations specify conditions of participation regarding facility management; health, safety, and sanitation requirements; and compliance with Federal, State, and local laws.

(5) *Responsibilities of Secretary related to habilitation facility requirements.*—No specific comparable provisions.

(6) *Survey and certification process.*—States are responsible for surveying and certifying compliance by ICFs/MR with Federal standards. The Secretary has the authority to validate State survey and certification findings through "look behind" surveys. ICFs/MR are subject to annual inspections of care to assure that services are adequate and to determine whether alternatives to institutional care are appropriate.

(7) *Enforcement process.*—Only certain remedies are available to the States and/or the Secretary in the event of noncompliance by an ICF/MR with the regulatory standards: (1) if the facility's deficiencies immediately jeopardize the health and safety of its clients, the facility's participation in Medicaid may be terminated; (2) if the facility's deficiencies do not immediately jeopardize the health and safety of its clients, payment for new admissions can be denied; (3) if the deficiencies do not immediately jeopardize the health and safety of clients, and upon application by the State, a plan of correction can be implemented under which all staffing and plant deficiencies are corrected within 6 months; (4) upon application by the State, a reduction plan can be implemented under which a facility (with deficiencies that do not jeopardize the health or safety of its clients) may permanently reduce the number of certified beds over a 36-month period while continuing to receive Federal Medic-

aid payments. The Secretary may not approve more than 15 reduction plans in any one year (with certain exceptions). Secretary's authority to approve correction or reduction plans expires on January 1, 1990.

(8) *Annual report*.—No provision.

House bill (sections 4231-4235)

(1) *Definition of "habilitation facility"*.—Renames ICFs/MR "habilitation facilities" and defines "habilitation facility" as an institution which is primarily engaged in providing health or habilitation services to individuals with mental retardation or a related condition, and is not primarily for the care and treatment of mental diseases. Provides that habilitation facilities meet the requirements specified below.

(2) *Requirements related to provision of services in habilitation facilities*.—Incorporates regulatory provisions into the statute by establishing "requirements" that must be met. Specifies that, to qualify for Medicaid payments, habilitation facilities must: (1) maintain or enhance the quality of life, independence, productivity, and integration into the community of each client; (2) provide continuous active treatment to each client in accordance with an individual program plan (IPP) coordinated and monitored by a qualified mental retardation professional; (3) provide, as needed to fulfill client IPP's, health and health-related services by qualified personnel, including physician, nursing, dental, and professional program services needed to implement the active treatment plan; (4) assure that health care is provided under supervision of a physician; and (5) maintain records.

(3) *Requirements related to clients' rights in habilitation facilities*.—Establishes specific "requirements" for client rights in place of current regulatory "conditions of participation" and "standards" regarding client protections. Requires habilitation facilities to protect and promote the rights of each client, including: (1) freedom from physical, verbal, sexual abuse, corporal or psychological punishment, aversive stimuli, and involuntary seclusion (except timeout periods of less than one hour); (2) freedom from physical or medical restraints used for discipline or staff convenience; (3) rights regarding privacy, confidentiality, and dignity; (4) reasonable accommodation of individual needs; (5) voicing of grievances to facility management; (6) participation in client groups and in community activities; (7) free choice regarding medical care and treatment; and (8) freedom from compulsion to perform services for the facility. Establishes limits on use of psychopharmacologic drugs. Identifies circumstances under which transfer or discharge of a client is permissible. Defines access and visitation rights. Requires facility, upon request of client, to manage and account for client's personal funds.

(4) *Requirements relating to administration and other matters*.—Requires that habilitation facilities: (1) be administered in a manner that promotes or maintains quality of life, independence, productivity, and integration into the community for each client; (2) meet applicable provisions of the Life Safety Code of the National Fire Protection Association (or comparable State requirements), except that the Secretary may waive specific provisions that would

result in unreasonable hardship, but only if client health and safety were not adversely affected; (3) maintain infection control programs and be equipped to protect the health and safety of clients, personnel, and the general public; and (4) operate services in compliance with all applicable Federal, State, and local laws and regulations and with accepted professional standards.

(5) Responsibilities of Secretary related to habilitation facility requirements.—Requires the Secretary to assure that the requirements which govern the provision of care in habilitation facilities, and the enforcement of such requirements, are adequate to protect the health, safety, welfare, and rights of clients and to promote the effective and efficient use of public monies. Requires the Secretary to publish, not later than January 1, 1991, an operational definition to “continuous active treatment.” Requires the Secretary to establish, by July 1, 1990, minimum guidelines for a State appeals process for transfers and discharges from habilitation facilities.

(6) Survey and certification process.—States would be responsible for surveying and certifying compliance by habilitation facilities (other than State facilities) with Federal requirements. Surveys would be unannounced and conducted on an annual basis. The Secretary would be responsible for conducting surveys of State-operated facilities and for conducting “look behind” reviews of a representative sample of non-State facilities. States with substandard survey performance would be subject to a reduction in related Federal administrative payments. Requires States and the Secretary to investigate allegations of client abuse and neglect as well as violations of the statutory requirements.

(7) Enforcement process.—Requires States to terminate a facility’s participation in the Medicaid program or to correct the deficiencies through temporary management if it is found that the clients’ health and safety are in immediate jeopardy. Where immediate jeopardy is not evidenced, a State could terminate or, in lieu of termination, impose one or more of the following sanctions: (1) denial of payments for new admissions; (2) civil money penalties; or (3) appointment of a temporary management. Authorizes the Secretary to impose the same sanctions and gives the Secretary primary enforcement authority in the case of State-operated facilities. In the case of any facility which fails to meet the requirements for three consecutive surveys, the State would be required to monitor the facility, impose civil monetary penalties, and deny payments for new admissions until compliance was achieved. Permanently authorizes correction and reduction plans and removes the limit on the number of reduction plans the Secretary is authorized to approve during any given year. Authorizes States to establish a program to reward habilitation facilities that provide highest quality of care. The reward could include public recognition and/or incentive payments. Reward program would be considered an administrative expense.

(8) Annual report.—Requires the Secretary to report to Congress annually on the extent to which habilitation facilities are complying with quality assurance provisions and the number and types of enforcement actions taken.

Effective January 1, 1991, for habilitation facility requirements and survey and certification requirements, except as otherwise pro-

vided, without regard to whether regulations have been promulgated. Enforcement provisions effective on date of enactment, without regard to whether regulations have been promulgated.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill.

(C) APPROPRIATE PLACEMENT FOR INDIVIDUALS WITH MENTAL
RETARDATION OR A RELATED CONDITION

Present law

Physicians are required to conduct initial certification and periodic recertification of each resident's need for ICF/MR care, develop plans for the care of each resident, and operate an approved utilization review program to assess such care. The State must also provide for external reviews known as inspections of care to assure that services are adequate and to determine whether alternatives to institutional care are appropriate.

House bill (sections 4241-4242)

Repeals existing requirements governing utilization review, including physician certification and inspections of care. In place of those provisions, requires States to establish a preadmission screening program applicable to all habilitation facility applicants, although screening of private pay patients would be delayed until 24 hours after conversion of Medicaid eligibility. Also requires States to annually review each habilitation facility resident entitled to Medicaid benefits to determine if he or she requires the level of care provided in a habilitation facility or requires community habilitation and supportive services. States would use criteria developed by the Secretary to make these determinations. Any client found no longer to require habilitation facility services would be oriented and discharged, with community habilitation and supportive services provided (or arranged for) by the State where necessary. Requires States to establish appeals procedures (that comply with required guidelines to be developed by the Secretary) regarding the transfer of individuals out of habilitation facilities. Requires Secretary to monitor the States' compliance with requirements. The preadmission screening program would have to be established by January 1, 1991.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill.

(D) PAYMENT FOR COMMUNITY HABILITATION AND SUPPORTIVE
SERVICES AND HABILITATION FACILITY SERVICES

Present law

Generally, States have discretion in setting payment rates, but the payments must be "consistent with efficiency, economy, and quality of care." The Secretary has by regulation required that States provide assurances to the Secretary that their payment methodology for ICFs/MR will not result in payments that exceed, in the aggregate, the estimated amounts that would be paid if Medicare reimbursement principles were applied.

House bill (section 4244)

Requires that payment for community habilitation and supportive services and habilitation facility services be reasonable and adequate to meet the costs of providing services efficiently and economically in conformity with applicable State and Federal laws, regulations, and quality and safety standards. Payment methods must not distinguish between State-operated service providers and other providers. Would prohibit use of capitation or other risk-based payment methodologies, and would deny Federal Medicaid payments for reimbursement of civil money penalties. Effective July 1, 1990 for payments for community habilitation and supportive services, or if later, 30 days after the date of publication of interim regulations. Effective January 1, 1991, for payments for habilitation facility services.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill.

(E) EMPLOYEE PROTECTIONS AND MISCELLANEOUS

Present law

(1) *Employee protections.*—Any ICF/MR reduction plan must provide for the protection of the interests of affected employees, including training and retraining where necessary, redeployment to community settings, and maximum efforts to guarantee employment.

(2) *State administration.*—Each State must designate a single agency to administer its Medicaid program.

House bill (sections 4247-4248)

(1) *Employee protections.*—Requires States to protect the interests of employees whose jobs would be jeopardized by a closure of, or reduction in the number of beds in, an habilitation facility, whether the facility is State-operated or private. Requires: (1) the preservation of rights, privileges and benefits under existing collective bargaining agreements; (2) the continuation of collective bargaining rights through any certified representative; (3) the protection of individual employees against a worsening of their job situation during the period of closure or reduction of a facility; (4) assurance

of employment for affected habilitation facility employees, including the maintenance of same compensation (including benefits) and comparable job responsibility (in the case of State-operated facilities, employees must be offered employment with a provider of community services or residential setting); (5) paid training or retraining to qualify for community services jobs; (6) a grievance procedure which gives an affected employee the choice of binding arbitration or a hearing before a State agency. These provisions do not entitle an affected employee to life-time employment, protect employees against discharge for good cause, or supercede or abrogate any collective bargaining agreement that contains such protections.

(2) *State administration*.—Permits States to assign Medicaid administrative functions related to the provision of services to persons with mental retardation or a related condition to a State agency responsible for developmentally disabled individuals.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill.

4. Frail Elderly Community Care Amendments

Section 4251 of House bill.

Present law

Under special waiver authorities (sections 1915(c) and 1915(d) of Medicaid law), States may cover a variety of home and community-based long-term care services for elderly persons who would otherwise require institutional care whose cost could be reimbursed by Medicaid. States define the services they wish to cover for a targeted population from a broad range of medical and nonmedical social services that are specified in law. These include case management, homemaker/home health aide services, personal care, adult day health, respite care, and other medical and social services that can contribute to the health and well-being of individuals and their ability to reside in a community-based setting. States may provide such services, however, only after they have demonstrated to the Secretary of HHS that coverage of these services would be budget neutral.

House bill

(A) COMMUNITY CARE AS OPTIONAL, STATEWIDE SERVICE

Establishes “community care for functionally disabled elderly individuals” as a new optional service that States may cover under their Medicaid plans without demonstrating budget neutrality.

(B) COMMUNITY CARE DEFINED

Defines “community care” as one or more of the following services furnished, according to an individual community care plan, to an individual who has been determined, after an assessment, to be a functionally disabled elderly individual: (1) homemaker/home

health aide services; (2) chore services; (3) personal care services; (4) nursing care services (other than continuous 24-hour nursing care services) provided by, or under the supervision of, a registered nurse; (5) respite care; (6) training for family members in managing the individual; (7) adult day health services; (8) in the case of an individual with chronic mental illness, day treatment or other partial hospitalization, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility); (9) such other home and community-based services (other than room and board) as the Secretary may approve. Requires that the first four services, if covered, be provided in a place of residence used as the individual's home.

(C) FUNCTIONALLY DISABLED ELDERLY INDIVIDUAL DEFINED

Defines an eligible "functionally disabled elderly individual" as a person who (1) is 65 years of age or older; (2) is determined to be functionally disabled; and (3) is eligible for Medicaid in the community because of low income and resources or because of large medical expenses (that result in a person "spending down" to qualify as "medically needy"). Provides that States may use a 6-month period for projecting medical expenses and income, in determining eligibility of medically needy persons of optional community care services.

In the event that a State discontinues a 1915(c) or 1915(d) waiver, specifies that States would be able to continue to cover under the optional community care benefit those elderly persons who received home and community-based services under these waivers, so long as they would be eligible for community care benefits, except for the income and resources standards used in the State for determining eligibility for persons living in the community. Allows Texas, which is providing personal care services to functionally disabled persons under a special demonstration project waiver authority (section 1115 of the Social Security Act), to extend community care services to aged and disabled persons who meet the waiver's test of functional disability and who meet the State's higher institutional income standard.

(D) FUNCTIONAL DISABILITY DEFINED

Defines as "functionally disabled" persons who (1) are unable, due solely to physical impairment or due solely to mental illness, to perform without substantial assistance from another individual at least 2 (or, at the option of the State, 3 or 4) of the following activities of daily living: bathing, dressing, toileting, transferring, and eating, or (2) have a primary or secondary diagnosis of Alzheimer's disease. Specifies that a person is considered to have a "mental illness" if the individual has a primary or secondary diagnosis of mental disorder as defined in the Diagnostic and Statistical Manual of Mental Disorders, 3rd edition.

(E) ASSESSMENTS OF FUNCTIONAL DISABILITY

Requires States, upon the request of an elderly person eligible for Medicaid, to provide a comprehensive functional assessment to determine whether or not an individual is functionally disabled. Requires that the assessment be based on a uniform minimum data

set specified by the Secretary and be conducted using an instrument specified by the State and approved by the Secretary.

(1) *Specification of assessment data set and instruments.*—By July 1, 1990, requires the Secretary to specify a minimum data set of core elements and common definitions for use in conducting assessments and to establish guidelines for use of the data set. Also requires the Secretary, by July 1, 1990, to identify one or more instruments for use by a State in conducting comprehensive functional assessments. Requires that States use one of the instruments identified by the Secretary or an instrument which the Secretary has approved as being consistent with the minimum data set of core elements, common definitions, and utilization guidelines.

(2) *Periodic review.*—Requires that individuals qualifying for community care services have their assessments periodically reviewed and revised not less often than once every 12 months.

(3) *Conduct of assessment by interdisciplinary teams.*—Requires that assessments and reviews be conducted by an interdisciplinary team designated by the States. Requires that the Secretary permit a State to provide for assessments and reviews through teams under contract with State or local agencies or with nonprofit or public organizations which do not provide and do not have a direct or indirect ownership or control interest in, or direct or indirect affiliation or relationship with, an entity that provides community care or nursing services. Requires that interdisciplinary teams (1) identify functional disabilities and need for community care (based on social, cognitive, and other relevant factors), and (2) determine, on the basis of the assessment, whether the individual is (or continues to be) functionally disabled.

(4) *Appeals procedures.*—Requires that each State electing to cover community care services as an optional benefit have in effect an appeals process for individuals adversely affected by eligibility determinations of the multidisciplinary team.

(F) INDIVIDUAL COMMUNITY CARE PLAN (ICCP)

Requires that community care be provided according to an individual community care plan (ICCP). Defines an "ICCP" as a written plan which (1) is established by a qualified community care case manager in face-to-face consultation with the individual and is based on a visit to the individual's residence and the most recent comprehensive functional assessment of the individual; (2) is periodically reviewed and revised by the case manager in face-to-face consultation with the individual and is based on a visit to the individual's residence and most recent assessment; (3) reflects the needs and preferences of the individual, consistent with coverage under the State's Medicaid plan, and, to the extent feasible, allows for and promotes the direction and oversight of community care by the individual; (4) specifies the community care to be provided, within any amount, duration, and scope limitation imposed on community care covered under the State Medicaid plan; (5) does not include community care for which payment is made by the individual or on the individual's behalf; and (6) may specify services (other than those to be provided under the plan) required by the individual. Specifies that neither an ICCP nor the State could restrict the

specific persons or individual (who are competent to provide community care under the State plan) that will provide care.

(1) *Qualified community care case manager defined.*—Defines a “qualified community care case manager” as a nonprofit or public agency or organization which (a) has experience in establishing, periodically reviewing, and revising assessments or ICCPs and in providing case management services to the elderly; (b) is responsible for assuring that community care covered under the State plan and specified in the ICCP is being provided and for visiting each individual receiving care at the individual’s residence not less often than once every 90 days; (c) in the case of non-public organization, does not provide, and does not have a direct or indirect ownership or control interest in, or direct or individual affiliation or relationship with, an entity that provides, community care or nursing facility services; (d) has procedures for assuring the quality of case management services it provides; (e) meets other standards established by the Secretary to assure that the case manager is competent to perform case management functions and that individuals whose care they manage are not at risk of financial exploitation; and (f) meets other standards established by the State.

(2) *Appeals procedures.*—Requires States to have in effect an appeals process for individuals who disagree with their ICCP.

(G) CEILING ON PAYMENT AMOUNTS AND MAINTENANCE OF EFFORT

(1) *Ceiling on payment amounts.*—Specifies that Federal Medicaid matching payments to a State for community care provided in any calendar quarter could not exceed 30 percent of the product of the following: (1) the average number of individuals receiving community care in the quarter, (2) the average per diem rate of payment for Medicare skilled nursing facility care in that State for the quarter, and (3) the number of days in the quarter.

(2) *Maintenance of effort.*—Requires States covering community care to report to the Secretary, in a format developed or approved by the Secretary, the amount of non-Federal funds obligated by the State (and its localities) for the provision of community care to functionally disabled elderly individuals in FY 1989 (other than its expenditures for services provided under 1915(c) waivers for home and community-based care). Requires the Secretary, in determining the amount of Federal Medicaid matching funds to be paid to a State for community care beginning in FY 1990, to reduce the total amount expended by a State (and its localities) for such services by the amount of expenditures reported by the State for FY 1989.

(3) *Direct payment to providers of community care.*—Provides that States are not authorized to permit payment for community care through a qualified community care case manager.

(H) MINIMUM REQUIREMENTS FOR COMMUNITY CARE

Requires that community care meet requirements for individuals’ rights and quality published or developed by the Secretary, including (1) a requirement that individuals providing community care be competent to provide care; (2) guidelines for minimum compensation for persons providing care to assure the availability and continuity of competent persons providing care, and (3) specifica-

tion of individuals' rights (including the right to free choice about care and treatment; freedom from restraints; privacy; confidentiality of personal and clinical records; voice grievances about treatment and care).

(I) MINIMUM REQUIREMENTS FOR COMMUNITY CARE SETTINGS

(1) *Community care setting defined.*—Defines "community care setting" as a setting in which community care is provided and which are either nonresidential, or residential (including foster homes, board-and-care facilities, or other group living arrangements, but not including nursing facilities) in which more than 2 unrelated adults reside and in which personal services (other than merely room and board) are provided.

(2) *Minimum requirements.*—Provides that a community care setting must meet certain requirements including requirements, (1) developed by the Secretary to assure that individuals receiving community care are protected from neglect, physical and sexual abuse, financial exploitation, inappropriate involuntary restraint, and incompetent caregivers; (2) relating to individuals' rights (including use of psychopharmacological drugs, access and visitation, and protection of resident funds); (3) for informing individuals of their rights; and (4) pertaining to licensing, Life Safety Code, sanitary and infection control and other physical environment standards.

(3) *Disclosure of ownership and control interests and exclusion of repeated violators.*—Provides that community care settings must disclose persons with an ownership or control interest in the setting. Specifies that a community care setting may not have as a person with an ownership or control interest any person who has been excluded from participation in Medicaid or who has had an ownership or control interest in settings which have been found repeatedly to be substandard or to have failed to meet the minimum requirements for settings specified in this section.

(J) SURVEY AND CERTIFICATION PROCESS

(1) *Certifications.*—Requires that States be responsible for certifying the compliance of providers of community care and community care settings with the minimum requirements. Requires the Secretary to be responsible for certifying the compliance of State providers and State community care settings with these same requirements. Requires that certification of providers and settings occur no less frequently than once every 12 months.

(2) *Reviews of providers.*—Requires that certification of a provider of community care be based on a periodic review of the provider's performance in providing care. Specifies that these periodic reviews be conducted annually by an agency other than the State Medicaid agency and be based on information that includes the views of case managers whose clients have received community care from the provider and from a sample of individuals receiving community care. If the Secretary has reason to question the compliance of a provider of community care with certification requirements, the Secretary could conduct a review of the provider and, on the basis of that review, make independent and binding deter-

minations concerning the extent to which the provider meets requirements.

(3) *Surveys of community care settings.*—Requires that certification of community care settings be based on a survey conducted without prior notice. Authorizes a civil money penalty of up to \$2,000 for persons who notify a community care setting of the time or date of the survey and requires the Secretary to review each State's procedures for avoiding giving notice of surveys. Requires that surveys be based on a protocol developed by the Secretary. Prohibits the use on survey teams of persons who are serving (or have served within the previous 2 years) as members of the staff of, or as a consultant to, the community care setting being surveyed, or who have a personal or familial financial interest in the setting. Requires the Secretary to conduct onsite surveys of a representative sample of community care settings in each State, within 2 months of the State survey, in a sufficient number to allow inferences about the adequacy of each State's survey. Provides that if the State has determined that a setting meets the requirements for certification, but the Secretary determines that the setting does not, then the Secretary's determination is binding and supersedes the State's. If the Secretary has reason to question the compliance of a setting with the certification requirements, the Secretary could conduct a survey of the setting, and on the basis of the survey, make an independent and binding determination about the extent to which the setting meets the requirements.

(4) *Investigation of complaints and monitoring of providers and settings.*—Requires the States and the Secretary to maintain procedures and adequate staff to investigate complaints of violations of certification requirements for providers of community care and community care settings.

(5) *Investigation of allegations of neglect and abuse.*—Requires States to provide for a process for receiving, reviewing, and investigating allegations of individual neglect and abuse (including injuries of unknown source) and misappropriation of individual property. Requires States to make a finding as to the accuracy of the allegations and to provide for public disclosure of findings.

(6) *Disclosure of results of inspections and activities.*—Requires the States and the Secretary to make available to the public information on all surveys, reviews, and certifications, including statements of deficiencies, copies of cost reports (if any) of providers and settings, copies of statements of ownership, and information about owners and other persons convicted of certain offenses. Requires the State to notify an individual receiving care and an immediate family member of a finding of substandard care. Requires each State to provide its Medicaid fraud and abuse control unit with access to information of the State agency responsible for surveys, reviews, and certifications.

(K) ENFORCEMENT PROCESS FOR PROVIDERS OF COMMUNITY CARE

Where the State or Secretary finds that a provider no longer meets the requirements and that its deficiencies immediately jeopardize the health or safety of individuals, the State or Secretary must take action to remove the jeopardy and correct the deficiency

or terminate the provider's participation and may, in addition provide for a civil money penalty. For providers of community care that no longer meet certification requirements and have deficiencies that do not immediately jeopardize the health and safety of individuals, authorizes the States and the Secretary to terminate the provider's participation in the program, and, in addition, to impose civil money penalties for each day the provider is out of compliance. Requires that the criteria for imposing civil money penalties be designed so as to minimize the time between the identification of violations and final imposition of the penalties and provide for incrementally more severe penalties for repeated or uncorrected deficiencies. The Secretary would exercise the State's authority with respect to State providers.

(L) SECRETARIAL RESPONSIBILITIES

Requires the Secretary to publish by July 1, 1990, interim regulations for community care and for community care settings, including regulations for functional assessments, qualifications of community care case managers, minimum requirements for community care, minimum requirements for community care settings, and survey protocols. Requires the Secretary to develop final requirements, and survey protocols and methods for evaluating and assuring the quality of community care, by October 1, 1991. Provides that interim and final requirements assure, through methods other than reliance on State licensure processes, that individuals receiving community care are protected from neglect, physical and sexual abuse, financial exploitation, inappropriate involuntary restraint, and the provision of health care services by persons who are not competent to provide this care. Specifies that States could impose, if they choose, requirements that are more stringent than the requirements published by the Secretary.

(M) APPLICABILITY IN STATES OPERATING UNDER DEMONSTRATION PROJECTS

For States providing community care under a section 1115 waiver, requires the State to meet requirements for community care as if it had elected to cover community care as an optional benefit.

(N) PAYMENT FOR COMMUNITY CARE

Requires States to pay for community care at rates which are reasonable and adequate (and which may not be established on a capitation basis or any other risk basis) to meet the costs of providing care, efficiently and economically, in conformity with applicable State and Federal laws, regulations, and quality and safety standards.

Prohibits Federal Medicaid matching payments from being used to pay for the costs of a civil money penalty or for the legal expenses in defense of a civil money penalty or for exclusion from the program, if there is no reasonable legal ground for the provider's case.

Also prohibits Federal matching payments for community care (1) which does not meet requirements published by the Secretary, or

(2) which is furnished in a community care setting that is found to be substandard, does not meet certification requirements, or to which the State after January 1, 1992, has not applied protocols and methods for assuring quality as developed by the Secretary. Provides that Federal matching payments for care provided in a community care setting found to be substandard or out of compliance with the minimum requirements could continue to be made, once and only once, if the setting is changed within 3 months and meets the requirements.

Prohibits Federal matching payments for community care provided by members of the family of the individual receiving care. Also prohibits Federal matching payments to the extent care is paid for by other programs.

(O) CONFORMING AMENDMENTS

Makes a number of conforming amendments in Medicaid law to accommodate new community care optional benefit. Also extends to July 1, 1990, waivers for the demonstration project, "Modification of the Texas System of Care for the Elderly: Alternatives to the Institutionalized Aged."

Effective date

In general, provisions establishing community care as an optional Medicaid benefit effective July 1, 1990. Provisions for Federal Medicaid matching payments for community care effective July 1, 1990, or 30 days after the publication of interim regulations by the Secretary setting forth minimum requirements for community care providers and community care settings. Provision prohibiting Federal matching payments to be used for civil money payments and provider's legal expenses in defense of civil money payments and exclusion from the program, effective for penalties imposed after the date of enactment. Waives the application of the Paperwork Reduction Act and Executive order 12291 to regulations required for community care.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill and provides for an extension, until July 1, 1990, of section 1115 waivers for the demonstration project, "Modification of the Texas System of Care for the Elderly: Alternatives to the Institutionalized Aged."

5. Hospice Coverage

Section 4261 of House bill.

(A) MANDATING HOSPICE COVERAGE

Present law

Under their Medicaid programs, States may cover hospice care as an optional benefit for terminally ill individuals who voluntarily

elect to receive hospice care in lieu of certain other benefits. Hospice care includes the services covered under Medicare's hospice benefit: nursing care; physical or occupational therapy or speech-language pathology; medical social services; home health aide and homemaker services; medical supplies (including drugs and biologicals) and medical appliances; physician services; short-term inpatient care (including both respite care and procedures necessary for pain control and acute and chronic symptom management); and counseling. In States covering hospice, a beneficiary's election of hospice is for a period or periods the State decides to cover. Hospice programs under Medicaid are required to meet Medicaid's requirements for organization and operation. According to the National Governors' Association survey of March 1989, 20 States offered hospice coverage under their Medicaid programs.

House bill

Requires that States cover hospice care under their Medicaid programs. Effective for payments for calendar quarters beginning on or after July 1, 1990, without regard to whether or not final regulations have been promulgated by that date. Permits delay where State legislation is required to comply.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill.

(B) PAYMENT FOR HOSPICE CARE

Present law

Medicaid law requires States covering hospice care to pay for hospice care in the same amounts, and according to the same methodology, as under Medicare. Medicare uses a prospective payment system to pay for hospice care. Under this payment system, hospices are paid one of four predetermined rates for each day a beneficiary is under the care of the hospice. The rates vary according to the level of care furnished to the beneficiary. The rates are as follows: (1) routine home care—\$63.17; (2) continuous home care—up to \$368.67; (3) inpatient respite care—\$65.33; and (4) general inpatient care—\$281.00.

For Medicaid-eligible residents of skilled nursing facilities (SNFs) and intermediate care facilities (ICFs), Medicaid law also permits a separate rate to be paid to the hospice program to take into account the room and board furnished by the facility, including performance of personal care services.

House bill

Requires States, in paying for hospice care, to pay amounts no lower than the amounts paid under Medicare, and to use the same methodology as Medicare's. For terminally ill SNF and ICF residents electing hospice, requires States to pay the hospice an additional amount equal to at least 95 percent of the rate that would

have been paid by the State to that facility for the Medicaid beneficiary.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House bill.

(C) CLARIFYING EFFECT OF HOSPICE ELECTION

Present law

Medicaid law requires terminally ill beneficiaries electing hospice to waive payment for services that are determined by the Secretary to be related to the treatment of the individual's terminally ill condition or that are duplicative of hospice care. Medicaid also specifies that election procedures must be consistent with those under Medicare. Medicare does not cover certain non-skilled services that States may cover under their Medicaid programs, e.g., personal care services.

House bill

Adds to Medicaid law a clarification that, in electing hospice care, a Medicaid beneficiary waives payment for services for which payment may otherwise be made under Medicare.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill.

(D) CONFORMING AMENDMENTS

House bill

Makes conforming amendments for changes described above.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill.

6. Amendments Relating to Nursing Home Reform

Section 4271 of House bill; section 5501 of Senate amendment.

(A) MORATORIUM ON IMPLEMENTATION OF FEB. 2, 1989 REGULATION

Present law

On February 2, 1989, HCFA published final regulations that revise and consolidate requirements that nursing homes must meet in order to participate in Medicare and/or Medicaid. These final regulations incorporate revisions to an October 1987 proposed regulation that represented HCFA's response to recommendations of

the Institute of Medicine report, "Improving the Quality of Care in Nursing Homes." The proposed regulations were published prior to the enactment of the nursing home reform provisions of OBRA 87 in December of that year. The final regulations also include provisions that apply to certain new requirements contained in OBRA 87. As published in February, most of the provisions of the final regulations would have become effective August 1, 1989, although OBRA 87 specified an effective date of October 1, 1990 for similar provisions. In July, HCFA issued notice in the Federal Register that it would delay implementation of the February 1989 regulations from August 1, 1989 to January 1, 1990.

House bill

Requires that HCFA's February 2 regulation on requirements for nursing homes participating in Medicare and/or Medicaid not be effective before October 1, 1990, insofar as these regulations apply to facilities participating under Medicaid.

Senate amendment

No provisions.

Conference agreement

The conference agreement includes the House bill.

(B) NURSE AIDE TRAINING

Present law

Effective January 1, 1990, OBRA 87 prohibits nursing facilities participating in Medicaid from using (on a full-time, temporary, per diem, or other basis) persons as nurse aides, for more than 4 months, unless the individual (a) has completed a training and/or a competency evaluation program approved by the State; and (b) is competent to provide nursing or nursing related services. OBRA 87 also prohibits a nursing facility from using persons as nurse aides unless it has consulted the State nurse aide registry to determine whether the person has satisfactorily completed a training and/or competency evaluation program and if the person has been involved in resident neglect or abuse.

OBRA 87 required the Secretary to establish requirements for State approval of nurse aide training and competency evaluation programs by September 1, 1988, and to specify in these requirements areas to be covered in programs, content of curriculum, minimum hours of initial (75 hours) and ongoing training and retraining, qualifications of instructors, and procedures for determining competency. HCFA has not yet published regulations for these requirements, although it has issued an interim guidance document, effective May 12, 1989, setting out approval criteria for the States.

OBRA 87 also authorized Federal matching payments for State activities required in connection with nurse aide training and competency evaluation programs, regardless of whether the programs are conducted in or outside nursing facilities or of the skill of the personnel involved in the programs. For the 8 calendar quarters beginning July 1, 1988, OBRA authorized enhanced Federal matching payments (the Federal matching rate for a State plus 25 per-

centage points, not to exceed 90 percent) for these activities. In subsequent years, the rate becomes 50 percent.

House bill

Includes a number of amendments to the OBRA 87 nurse aide training and competency evaluation requirements:

(1) *Delay in requirement.*—Delays from January 1, 1990, until October 1, 1990, the date by which nurse aides must complete training and/or competency evaluation programs and must be determined to be competent to provide services.

(2) *No compliance actions before effective date of guidelines.*—Prohibits the Secretary from taking (or continuing) any compliance action against a State for its failure to meet the law's requirements for nurse aide training and competency evaluation programs before the effective date of HCFA guidelines for such programs (May 12, 1989), if the State had made a good faith effort to meet the requirements.

(3) *Publication of proposed regulations.*—Requires the Secretary to issue proposed regulations on nurse aide training and competency evaluation programs not later than 90 days after enactment of this Act.

(4) *Clarification of grace period for nurse aide training of individuals.*—Specifies that training and competency evaluation requirements apply to all persons who have worked (on a full-time, temporary, or per diem basis) as nurse aides for 90 days or more in any nursing facility.

(5) *Requirements for training and evaluation programs.*—Adds to requirements that the Secretary must establish for approval of nurse aide training and competency evaluation programs a requirement that programs cover the care of cognitively impaired residents, and amends the specifications for competency programs to require such programs to cover, among other things, recognition of mental health and social service needs of residents. Provides that nurse aides may establish competency (1) through procedures or methods other than the passing of a written examination and (2) at the nursing facility at which the aide is (or will be) employed, unless the facility is out of compliance with requirements for participation. Prohibits the imposition on nurse aides of any charges (including any charges for textbooks and other required course materials) for training and competency programs. Applies to programs offered on or after the end of the 90-day period beginning on the date of enactment, but shall not affect competency evaluations conducted under programs offered before the end of this period.

(6) *Delay and transition in 75-hour training program requirement.*—Provides that nurse aides shall be considered to have completed a training and competency evaluation program, if, as of July 1, 1989, the aide had received 60 hours of initial training, and at least 15 hours of supervised practical nurse aide training or regular in-service education.

(7) *Clarification of State responsibility to determine competency.*—Prohibits States from using subcontracts or other devices to make final nurse aide competency determinations.

(8) *Clarification of temporary enhanced Federal financial participation for nurse aide training by nursing facilities.*—Clarifies that

Federal matching payments for nurse aide training and competency evaluation programs, including enhanced Federal matching, are available for the costs of nurse aides to complete competency evaluation programs. Also prohibits the Secretary from taking into account or allocating amounts expended for nurse aide training and competency evaluation activities conducted before October 1, 1990, on the basis of the proportion of nursing facility residents entitled to Medicare or Medicaid.

Senate amendment (section 5501)

Includes a number of amendments to the OBRA 87 nurse aide training and competency evaluation requirements:

- (1) *Delay in requirement.*—Identical provision.
- (2) *No compliance actions before effective date of guidelines.*—No provision.
- (3) *Publication of proposed regulations.*—No provision.
- (4) *Clarification of grace period for nurse aide training of individuals.*—No provision.
- (5) *Requirements for training and evaluation programs.*—No provision.
- (6) *Delay and transition in 75-hour training program requirement.*—Requires States to waive training and competency evaluation requirements for nurse aides who (1) were hired as aides before January 1, 1990, (2) can demonstrate to the satisfaction of the State that they served as an aide at one or more facilities of the same employer in the State for at least 24 consecutive months, and (3) have completed a 15-hour course of instruction in basic skills designated by the State. Also requires States to waive training and competency evaluation requirements for persons who (1) were employed as a nurse aide before January 1, 1990, (2) can demonstrate to the satisfaction of the State that they have served as a nurse aide in the State in the preceding 24-month period, and (3) have completed a nurse aide training program that was required by the State and established before December 22, 1987.
- (7) *Clarification of State responsibility to determine competency.*—No provision.
- (8) *Clarification of temporary enhanced Federal financial participation for nurse aide training by nursing facilities.*—No provision.

Conference agreement

- (1) *Delay in requirement.*—The conference agreement includes the House bill.
- (2) *No compliance actions before effective date of guidelines.*—The conference agreement does not include the House bill.
- (3) *Publication of proposed regulations.*—The conference agreement does not include the House bill.
- (4) *Clarification of grace period for nurse aide training of individuals.*—The conference agreement does not include the House bill.
- (5) *Requirement for training and evaluation programs.*—The conference agreement includes the House bill.
- (6) *Delay and transition in 75-hour training program requirement.*—The conference agreement includes the House bill with the following additional modifications. A nurse aide is considered to have completed an approved training and competency evaluation

program if the aide had completed a training course of at least 100 hours and was found competent (whether or not by the State) before July 1, 1989. In addition, States are authorized to waive the competency evaluation (but not the training) requirements with respect to individuals who can demonstrate that he or she has served as a nurse aide at one or more facilities of the same employer in the State for at least 24 consecutive months before the date of enactment.

(7) *Clarification of State responsibility to determine competency.*—The conference agreement does not include the House bill.

(8) *Clarification of temporary enhanced Federal financial participation for nurse aide training by nursing facilities.*—The conference agreement includes the House bill.

(C) PREADMISSION SCREENING AND ANNUAL RESIDENT REVIEW

Present law

OBRA 87 requires States, effective January 1, 1989, to establish preadmission screening programs to determine for mentally ill or mentally retarded individuals seeking admission to a nursing home whether they require the level of services provided by a nursing home and, if so, whether they require active treatment. Effective January 1, 1989, nursing facilities participating in Medicaid must not admit any new resident who is mentally ill or mentally retarded, unless the State has determined, prior to admission, that the prospective resident requires the level of services provided by the nursing facility, and whether he or she requires active treatment. OBRA 87 also requires States to review, on an annual basis, all residents who are mentally ill or mentally retarded to determine whether their continued placement is appropriate and whether they require active treatment. The first of these annual reviews must be completed by April 1, 1990. These preadmission screening and annual resident review requirements are often referred to as PASARR requirements. The law requires that certain residents be discharged if their placement in a nursing facility is found to be inappropriate. OBRA 87 authorizes the Secretary and States to enter into agreements, prior to April 1, 1989, that specify alternative disposition plans (ADPs) for persons who must be discharged from the facility. ADPs provide additional time for the States to arrange for the disposition of persons who must be discharged.

OBRA 87 required the Secretary to issue, by not later than October 1, 1988, minimum criteria for States to use in making determinations as to whether a mentally ill or mentally retarded individual requires the level of services provided by a nursing facility. In May 1989, HCFA issued interim guidelines (effective May 26) to the States for use in making determinations, but indicated that it intends to use the formal rule-making process, with a comment period, before making the guidelines' criteria binding on the States.

House Bill

Includes a number of amendments to OBRA 87 PASARR requirements:

(1) *No compliance actions before effective date of guidelines.*—Prohibits the Secretary from taking (or continuing) any compliance

action against a State for failure to meet the law's requirements for preadmission screening, if the State had made a good faith effort to comply with the requirements before the effective date of HCFA's guidelines for these programs (May 26, 1989).

(2) *Publication of proposed regulations.*—Requires the Secretary to issue proposed regulations on PASARR requirements not later than 90 days after enactment of this Act.

(3) *Clarification with respect to admissions and readmission from a hospital.*—Specifies that preadmission screening requirements do not apply to nursing facility residents who are being readmitted to the nursing facility after a hospital stay. Also provides that preadmission screening requirements do not apply to persons (1) who are admitted to the nursing facility directly from a hospital after receiving acute inpatient care at the hospital; (2) who require nursing facility services for the condition for which the individual received care in the hospital; and (3) whose attending physician has certified, before admission to the facility, that the person is likely to require less than 30 days of nursing facility services.

(4) *Charges applicable in cases of certain Medicaid eligible individuals.*—Provides that nursing facility residents who are Medicaid eligible, but for whom Medicaid payments are not being made because their income exceeds State payments for this care, may not be charged more than the Medicaid rate for their nursing facility care.

(5) *Delay in application to private pay residents.*—Provides that preadmission screening and annual resident review requirements do not apply to mentally ill or mentally retarded persons who are not eligible for Medicaid until such time as they become entitled to benefits (with preadmission screening required to be done within 24 hours after eligibility is established). Specifies that this amendment shall not prohibit a State from imposing preadmission screening and annual resident review requirements on persons who are not Medicaid eligible at the time of admission to a nursing facility. Prohibits the Secretary from imposing any sanction on States which have failed to apply the preadmission requirements to persons who are not Medicaid eligible at the time of their admission.

(6) *Denial of payments for certain residents not requiring nursing facility services.*—Prohibits Federal matching payments for nursing facility services for persons who do not require the level of services provided by the nursing facility (other than for persons who have resided in the facility for at least 30 months and who are determined not to need such care).

(7) *No delegation of authority to conduct screening and reviews.*—Prohibits State mental health authorities and State mental retardation or developmental disability authorities from delegating (by subcontract or otherwise) their PASARR responsibilities to nursing facilities (or entities that have a direct or indirect affiliation or relationship with these facilities).

(8) *Annual reports.*—Requires States to report to the Secretary annually on the number and disposition of residents who are discharged from nursing facilities (1) because they do not require nursing facility care, have resided in the facility for less than 30 months and require active treatment; and (2) because they do not require nursing facility care and do not require active treatment.

Also requires the Secretary's annual report on nursing facility compliance with new requirements and enforcement actions to include a summary of information reported by States on the disposition of residents discharged from nursing homes.

(9) *Revision of alternative disposition plans.*—Authorizes States to revise their agreements for alternative disposition plans before October 1, 1990, subject to the approval of the Secretary, but only if under the revised agreement all residents who do not require nursing facility care are discharged from the facility by not later than April 1, 1994.

(10) *Definition of mentally ill.*—Modifies the definition of mental illness from "a primary or secondary diagnosis of mental disorder (as defined in DSM-III)" to a "serious mental illness as defined by the Secretary."

(11) *Substitution of "specialized services" for "active treatment".*—Substitutes the term "specialized services" for the term "active treatment."

Senate amendment

No provision.

Conference agreement

The conference agreement includes item (2) of the House bill.

(D) OTHER AMENDMENTS

(1) *Assurance of appropriate payment amounts*

Present law

OBRA 87 requires States to take into account in their payments to nursing facilities the costs of complying with new requirements relating to the provision of services, residents' rights, and administration. OBRA also requires that each State submit to the Secretary a State plan amendment to provide for an appropriate adjustment in payment amounts for nursing facility services.

House bill

Provides that States also take into account in their payments to nursing facilities the costs of services required to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident eligible for Medicaid. Also requires that State plan amendments include a detailed description of the specific methodology to be used in determining the appropriate adjustment in payment amounts for nursing facility services.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill.

(2) Disclosure of information of quality assessment and assurance committees

Present law

OBRA 87 requires that nursing facilities maintain a quality assessment and assurance committee which (1) meets at least quarterly to identify quality assessment and assurance issues, and (2) develops and implements appropriate plans of action to correct identified quality deficiencies.

House bill

Provides that a State or the Secretary may not require disclosure of the records of the quality assessment and assurance committee, except for determining the facility's compliance with the requirement for maintaining the committee.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill.

(3) Period for resident assessment

Present law

OBRA 87 requires that nursing facilities conduct a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity. This assessment must be performed promptly upon, but no later than 4 days after, admission to the facility.

House bill

Extends the time limit for a resident's assessment from 4 days to 14 days after admission.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill.

(4) Clarification of responsibility for services for mentally ill and mentally retarded

Present law

OBRA 87 requires nursing facilities to provide nursing and related services and specialized rehabilitative services, medically-related social services, pharmaceutical services, dietary services, an ongoing program of activities, and certain dental services.

House bill

Requires that facilities also provide treatment and services required by mentally ill and mentally retarded residents not other-

wise provided or arranged for (or required to be provided or arranged for) by the State.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill.

(5) Residents' rights to refuse transfers

Present law

The Medicare Catastrophic Coverage Act of 1988 amended Medicare's coverage of skilled nursing facility services, effective January 1, 1989. Among other things, this legislation eliminated a prior hospitalization requirement that persons had to meet in order to qualify for benefits. It also modified coverage by authorizing up to 150 days of care per calendar year. As a result of these changes, many Medicaid-eligible nursing facility residents are now eligible for Medicare coverage of their care. However, a resident must occupy a Medicare-certified bed in order for a facility to receive Medicare payment. In order to occupy such a bed, a resident may have to be moved. Medicare regulations provide that a resident can be transferred or discharged only for medical reasons or for his welfare or that of other patients or for non-payment of his stay.

House bill

Adds to residents' rights established under OBRA 87 a new right for residents to refuse a transfer to another room within a facility, if a purpose of the transfer is to relocate the resident from a non-Medicare certified portion of the facility to a Medicare-certified portion of the facility. Provides that a resident's refusal to be transferred will not affect the resident's eligibility for Medicaid or the State's entitlement to Federal matching payments for the resident's care.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill.

(6) Resident access to clinical records

Present law

OBRA 87 requires nursing facilities to assure the confidentiality of a resident's personal and clinical records.

House bill

Adds to this requirement the right of the resident to have access to current clinical records promptly, upon request.

Conference agreement

The conference agreement does not include the House bill.

(7) Inclusion of State notice of rights in facility notice of rights

Present law

Among the residents' rights established under OBRA 87 is the requirement that nursing facilities make available to each resident, upon reasonable request, a written statement of rights of the resident in the facility.

House bill

Requires facilities to include in the written statement of rights that they are currently required to provide residents, a copy of the State notice of the rights and obligations of residents (and spouses of residents) under Medicaid.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill.

(8) Removal of duplicative requirement for qualifications of nursing home administrators

Present law

OBRA 87 requires the administrator of a nursing facility to meet standards established by the Secretary.

House bill

Repeals other requirements in Medicaid law pertaining to State programs for the licensing of nursing home administrators.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill.

(9) Clarification on findings of neglect

Present law

OBRA 87 requires States (through their agencies responsible for surveys and certification of nursing facilities) to review, investigate, and make findings regarding allegations of resident neglect and abuse and misappropriation of resident property by a nurse aide or another individual used by the facility to provide services.

House bill

Provides that a State cannot make a finding of neglect by an aide or individual, if the aide or individual demonstrates that neglect was caused by factors beyond the control of the individual.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill.

*(10) Timing of public disclosure of survey results**Present law*

OBRA 87 requires States and the Secretary to make available to the public information on all surveys and certifications of nursing facilities, including statements of deficiencies and plans of correction.

House bill

Requires that survey and certification information be made available to the public within 14 calendar days after this information is made available to the facilities.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill.

*(11) Clarification of applicability of enforcement rules to dually-certified facilities**Present law*

For nursing homes found to be out of compliance with the requirements for participation, OBRA 87 establishes enforcement procedures that are to be applied to (1) skilled nursing facilities participating in Medicare, and (2) nursing facilities participating in Medicaid. OBRA did not specifically address, however, the procedures and process by which enforcement actions are to be taken against nursing facilities that are certified to participate in both Medicaid and Medicare.

House bill

Provides that the enforcement rules for facilities participating in Medicaid apply also to those facilities participating in both Medicaid and Medicare.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House bill.

*(12) Clarification of Federal matching rate for survey and certification activities**Present law*

Beginning in FY 1991, OBRA provides enhanced Federal matching payments for State survey and certification activities. These will be at the rate of 90 percent in FY 1991, 85 percent in FY 1992, 80 percent in FY 1993, and 75 percent in FY 1994 and thereafter.

House bill

Clarifies that during the period before October 1, 1990, the Federal matching rate for survey and certification is the current 75 percent.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House bill.

*(13) Miscellaneous technical corrections**House bill*

Makes a number of miscellaneous technical corrections.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill.

*(14) Delay in requirement for remedies**Present law*

OBRA 87 revises and expands the sanctions that States and the Secretary may impose against nursing facilities found to be out of compliance with the requirements for participation. OBRA 87 required States to amend their Medicaid plans by October 1, 1989, to include certain sanctions that they could use to impose against noncompliant nursing facilities. OBRA 87 also required the Secretary to provide guidance to the States on these sanctions by October 1, 1988, but specified that the failure of the Secretary to provide this guidance did not relieve a State of its responsibility for establishing the sanctions by the statutory deadline. The Secretary has not yet issued regulations providing this guidance.

House bill

No provision.

Senate amendment

Delays until April 1, 1991, the requirement that States establish certain sanctions to be imposed against noncompliant nursing facilities. Effective as if included in OBRA 87.

Conference agreement

The conference agreement does not include the Senate amendment.

7. Miscellaneous and Technical Provisions

Sections 4272 through 4276 of the House bill.

(A) MEDICARE BUY-IN PROVISIONS

*(1) Medicare buy-in for premiums of certain working disabled**Present law*

No provision.

House bill (section 4272)

Requires States to pay Medicare premiums and cost-sharing for certain working disabled persons who are eligible for Medicare as a result of the new section 1818A of the Act, as added by section 10112(b) of the House bill, whose income does not exceed 200 percent of the Federal poverty line, and who are not otherwise eligible for Medicaid. Permits States to require individuals with incomes above 150 percent of the poverty line to contribute to the cost of their own Medicare premiums and cost-sharing, in the form of a premium to be set on a sliding scale from 0 percent (at 150 percent of poverty) to 100 percent (at 200 percent of poverty). Applies to payments for calendar quarters beginning on or after July 1, 1990, regardless of whether implementing regulations have been promulgated by that date. Delay permitted where State legislation required.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House bill with the following modifications: (1) coverage would be limited to Medicare Part A premiums, and (2) individuals would be subject to a resource test of twice the SSI level.

*(2) Technical corrections to Medicare buy-in for the elderly**Present law*

MCCA require States to pay Medicare cost-sharing for "qualified Medicare beneficiaries," those with incomes below 100 percent of the poverty line and resources no more than twice the amount permissible under the SSI program. Eligibility for this assistance begins in the month following the month during which the individual applies. The coverage requirement is being phased in on a timetable that began January 1, 1989, and ends January 1, 1993.

House bill

Permits States to grant retroactive eligibility for certain qualified Medicare beneficiaries. For a person determined to be a qualified Medicare beneficiary before October 1989, eligibility may begin with the earliest month in 1989 during which the person would have been eligible if he or she had applied in the preceding month. Makes a technical correction in a provision relating to coverage in section 209(b) States, to clarify that these States are not exempt from the rules governing eligibility standards for qualified Medicare beneficiaries. Effective as if included in MCCA.

Senate amendment

No provision.

Conference agreement

The conference agreement follows items (2) and (3) of the House bill with a modification relating to application of the disproportionate share adjustment in the State of Missouri during the period July 1, 1988 through June 30, 1990. The agreement provides that the State is to be treated as having met the requirement if, in phasing in adjustments by group or facility, the total amount of disproportionate share adjustment payments during the period is not less than the total of such payments otherwise required for such period.

(D) MEDICAID PROVISIONS RELATING TO DEMONSTRATION OF
EFFECTIVENESS OF MINNESOTA FAMILY INVESTMENT PLAN

House bill (section 4275)

Section 10265 of the House bill, relating to the AFDC program, permits Minnesota to conduct, with the approval of the Secretary, a demonstration of an alternative program designed to assist families in becoming self-supporting and caring for their children more effectively. Section 4275 of the House bill provides that, in the event the Secretary approves the Minnesota demonstration, the Secretary shall require the State to: (a) treat participating families as categorically eligible for Medicaid; (b) grant extended Medicaid coverage to families terminated from the project as a result of increased employment income, as provided under the Family Support Act of 1988; and (c) provide 12 months of additional Medicaid coverage to a family terminated from the project as a result of collection or increased collection of child support. Requires Federal matching payments for medicaid costs for participating families, provided that aggregate payments are not greater than those that would have been made for the same families in the absence of the project.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House bill with a modification providing for a 4 month extension of coverage in the case of a family terminated as a result of collection or increased collection of child support.

(E) MISCELLANEOUS PROVISIONS

*(1) Fraud and abuse technical amendments**Present law*

The Secretary may exclude from Medicare and Medicaid a provider whose license has been revoked, suspended, or otherwise lost for reasons related to competence, performance, or financial integrity. Providers excluded from Medicare and/or Medicaid may still be paid for emergency services to beneficiaries.

House bill (section 4276(a))

Permits exclusion of a provider who has lost the right to apply for or renew a license on the same grounds. Provides that the exception permitting payment for emergency services by excluded providers does not apply to services furnished in a hospital emergency room.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House bill with a modification clarifying that HMOs with Medicare risk-sharing contracts or Medicaid prepaid plans may not employ or contract with (1) individuals or entities excluded from participation in Medicare or Medicaid for the provision of health care, utilization review, medical social work, or administrative services, or (2) any entity for the provision (directly or indirectly) through such an excluded individual or entity of such services.

*(2) Psychiatric hospitals**Present law*

(A) The Deficit Reduction Act of 1984 (DEFRA, P.L. 98-369) provided that a State may cover inpatient psychiatric hospital services to beneficiaries under age 21 only if the facility (or part of a facility) meets the Medicare definition of a psychiatric hospital.

(B) Current law provides for intermediate sanctions to be imposed on nursing facilities and intermediate care facilities for the mentally retarded (ICFs/MR) that fail to meet the requirements for participation, but has no such provisions for inpatient psychiatric hospitals. Section 4231 of the House bill redesignates ICFs/MR as "habilitation facilities" and establishes a new section 1927 of the Act setting forth standards and enforcement procedures for these facilities.

House bill (section 4276(b))

(A) Allows the Secretary to specify in regulations alternative settings in which inpatient psychiatric services may be covered. Effective as if included in DEFRA.

(B) Replaces current provisions relating to intermediate sanctions for ICFs/MR (rendered obsolete by section 4231 of the House bill) with new sanction provisions for inpatient psychiatric hospitals, as follows:

(i) If a State finds that a psychiatric hospital fails to meet certification requirements then, if the deficiencies immediately jeopardize the health and safety of patients, the State must terminate the hospital's Medicaid participation. If there is no such immediate jeopardy, the State may choose to terminate participation, deny payment for individuals admitted after the date of the finding, or both.

(ii) If non-compliance continues for 3 months, the State must deny payment for new admissions; if it continues for 6 months,

Federal funding for services in the hospital is denied until the hospital achieves compliance. Federal funding may be continued during the 6-month period if the State has an approved plan for corrective action, provided the State agrees to repay the funds if the plan is not complied with.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill.

(3) Clarification of application of 133 percent income limit to medically needy

Present law

(A) States may not provide Medicaid to persons with a countable family income greater than 133⅓ percent of the State's maximum AFDC for a family of the same size. The restriction does not apply to target groups of pregnant women and children, qualified Medicare beneficiaries, persons receiving or eligible for cash assistance (or who would be eligible if they were not in an institution), and persons in an institution meeting an income standard no higher than 300 percent of the maximum SSI benefit. Although the 133⅓ percent limit has been understood as applying only to the "medically needy," Congress has added a number of additional mandatory or optional Medicaid coverage groups without specifying whether the limit was intended to apply to them.

(B) In determining eligibility for the aged, blind, and disabled, section 209(b) States may use more restrictive income and resource standards than those used for SSI. MCCA provided that 209(b) States may not use more restrictive methodologies in determining income and resources than those used under SSI, but did not modify a conflicting existing provision of law.

House bill (section 4276(c))

(A) Clarifies that the income limit applies only to the "medically needy" (and not to a variety of other optional or mandatory coverage groups not explicitly exempt from the limit under current law).

(B) Modifies the conflicting provision to clarify that methodologies used by section 209(b) States in determining income and resources for the aged, blind, and disabled may be less restrictive, but not more restrictive, than those used under SSI.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill. The conference agreement prohibits the Secretary from issuing, before December 31, 1990, a final regulation implementing the proposed regulation published on September 26, 1989, 54 Fed. Reg. 39421, insofar as it changes in any way the methods for establishing the medically needy income level for a single individual currently used

by the States of Arkansas, California, Kansas, Maine, Maryland, Montana, North Dakota, Oklahoma, Pennsylvania, Rhode Island, and Virginia.

(4) Health maintenance organizations

Present law

(A) States may generally enter into Medicaid risk contracts only with HMO's or similar organizations no more than 75 percent of whose enrollment consists of Medicare or Medicaid beneficiaries. The requirement may be modified or waived for an HMO that is a public entity if the Secretary determines that special circumstances warrant the modification and the HMO is making reasonable efforts to enroll persons other than Medicare/Medicaid beneficiaries.

(B) Medicaid beneficiaries enrolling in Federally qualified HMOs (those determined by the Secretary to meet the requirements of Title XIII of the Public Health Service Act) or certain organizations receiving Federal grant funds may be required to remain enrolled for a period of up to 6 months; the State may agree to continue payments to the HMO on behalf of an enrollee for up to 6 months even if the enrollee loses Medicaid eligibility (these provisions are known as "lock-in" and "guaranteed enrollment period," respectively).

(C) A Medicaid beneficiary may lose eligibility for a short interval and then be determined eligible again. In some States, if such an individual was enrolled under a Medicaid HMO contract at the time eligibility was terminated, the State will automatically reenroll the individual in the same HMO when eligibility is reestablished. This practice is not explicitly authorized by law.

(D) Before 1981, States could contract with an HMO only if the HMO was Federally qualified or "provisionally qualified," having applied for Federal qualification and awaiting final determination. OBRA 81 permitted States to make their own determinations that an HMO was eligible for a contract, rendering the "provisionally qualified" category obsolete.

House bill (section 4276(d))

(A) Deletes the requirement that the Secretary determine that special circumstances warrant a modification before modifying the 75 percent rule for a public entity.

(B) Extends the lock-in and guaranteed enrollment period options to "competitive medical plans," organizations which are not Federally qualified HMOs but which have entered into a risk-sharing contract with the Medicare program; lock-in for such an organization is permissible if it complies with the 75 percent Medicare/Medicaid enrollment maximum.

(C) Authorizes automatic HMO reenrollment for individuals whose period of ineligibility is no longer than 2 months, provided that the individual retains the right to request disenrollment from the organization.

(D) Eliminates provisions relating to provisionally qualified HMOs.

Senate amendment

No provision.

Conference agreement

The conference agreement does not contain the House bill. The conference agreement extends the Minnesota Prepaid Medicaid Demonstration Project from June 30, 1990, to June 30, 1991.

*(5) Personal care services**Present law*

Some State Medicaid programs cover personal care services, such as bathing and grooming, which can assist individuals who might otherwise require institutional care to remain at home. Although personal care services are not among the optional Medicaid services set forth in the statute, the Secretary has authorized coverage of personal care services in a beneficiary's home under a general authority to approve the inclusion of additional medical or remedial services in a State Medicaid plan. The services are defined in Medicaid regulations as those provided by a qualified person who is supervised by a registered nurse and who is not a member of the individual's family, pursuant to a plan of treatment prescribed by a physician.

House bill (section 4276(e))

Adds personal care services to the statutory list of optional Medicaid services. Incorporates the current regulatory definition in the statute, but provides that services may be furnished in settings other than a beneficiary's home (but not a hospital or nursing facility). Effective on enactment and applies to personal care services furnished before enactment pursuant to regulations in effect July 1, 1989.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill.

*(6) Supervision of health care of residents of nursing facilities by nurse practitioners and clinical nurse specialists acting in collaboration with physicians**Present law*

Health care for residents of nursing facilities must be provided under the supervision of a physician.

House bill (section 4276(f))

Permits care for residents of nursing facilities to be provided under the supervision of a nurse practitioner or clinical nurse specialist who is not employed by the facility but who is working in collaboration with a physician. Applies to nursing facility services furnished on or after October 1, 1990, regardless of whether implementing regulations have been promulgated.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill.

*(7) Codification of coverage of rehabilitation services**Present law*

Rehabilitative services are among the optional Medicaid benefits States are permitted to offer. Medicaid regulations define these as medical or remedial services recommended by a physician or other licensed practitioner and designed to reduce physical or mental disability and restore an individual to the best possible functional level.

House bill (section 4276(g))

Incorporates the regulatory definition in the statute, with minor changes.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill.

*(8) Institutions for mental diseases**Present law*

The Social Security Amendments of 1972 (P.L. 92-603) permitted States to provide Medicaid benefits to persons aged 65 or over in institutions for mental diseases (IMDs); other residents of IMDs are ineligible for Medicaid. States may also cover services in inpatient psychiatric hospitals for persons under age 21.

House bill (section 4276(h))

Requires the Secretary to study the current implementation of the exclusion of IMD residents under age 65 and to submit a report to Congress by October 1, 1990, including recommendations for any changes in current policies or guidelines that may be appropriate in the light of any changes since 1972 in the delivery of inpatient mental health services.

Provides that any determination by the Secretary that Kent Community Hospital Complex or Saginaw Community Hospital (both in Michigan) is an IMD shall not take effect until 180 days after the report is submitted.

Requires the Secretary to study the costs and benefits of Medicaid coverage of public subacute psychiatric facilities as an alternative to care in acute psychiatric facilities, including an examination of cost differences between subacute and acute facilities, the effectiveness of subacute facilities in preventing hospitalization, and their impact on access and quality. Requires the Secretary to submit a report to Congress by October 1, 1990, with recommendations on continued coverage of subacute facilities.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill with a modification consolidating the studies of IMDs and subacute psychiatric facilities.

(9) Timely payment under waivers of freedom of choice of hospital services

Present law

Section 2175 of OBRA 81 permitted a State to obtain a waiver of certain Medicaid requirements, including the beneficiary's right to choose a provider of services, in order to establish a system of selective contracting with providers. Medicaid law includes requirements that States pay health care practitioners, such as physicians, on a timely basis, but makes no such provision for other types of providers, such as hospitals.

House bill (section 4276(i))

Extends prompt payment requirements to any type of provider participating under a selective contracting waiver. Effective as of first quarter beginning more than 30 days after enactment.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill.

(10) Home and community-based services waivers

Present law

(A) Section 2176 of OBRA 81 permitted States to obtain waivers of certain Medicaid requirements in order to establish a home and community-based service program for a defined population (such as the aged or the mentally retarded) of persons who would otherwise require long-term institutional care. Costs for room and board are excluded from those which a State may include as Medicaid costs under a waiver.

(B) In order to obtain a Section 2176 waiver, the State must demonstrate that average per capita Medicaid costs for waiver participants are no greater than would have been incurred in the absence of the waiver.

(C) One of the services that may be furnished under a home and community-based services waiver is respite care, services that allow family or other voluntary caregivers to take time away from their responsibility for a patient's care.

(D) OBRA 87 established requirements for screening of mentally retarded or mentally ill patients before admission to a nursing facility, to determine whether alternative treatment is more appropriate; the requirements apply to all persons admitted on or after January 1, 1989.

House bill (section 4276(j))

(A) Provides that the "room and board" exclusion does not apply to the share of rent and food costs attributable to an unrelated care-giver who is residing with a waiver participant and without whom the participant would require institutional care. Applies to services furnished on or after enactment.

(B) Provides that, in estimating per capita costs in the absence of a waiver for persons with mental retardation or a related condition who are residents of an ICF-MR whose Medicaid participation has been terminated, the State may use the costs that would have been incurred if the facility has not been terminated.

(C) Provides that, so long as the State meets the cost-effectiveness test for a waiver, the Secretary may not limit the hours or days of respite care that may be provided.

(D) Provides that, in the case of a waiver program for the mentally retarded, a State may revise its per capita cost estimates to take into account increases in ICF-MR or habilitation facility costs resulting from implementation of the pre-admission screening requirement.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill.

*(11) Spousal impoverishment**Present law*

(A) MCCA required States to provide for a period of Medicaid ineligibility for persons in nursing facilities who dispose of assets for less than fair market value within 30 months before entering the facility or applying for Medicaid, whichever is later. The restriction does not apply to disposal of assets by an institutionalized individual's spouse, even if the resources disposed of might otherwise have been available to contribute to the cost of the institutionalized individual's care. Applies to transfers occurring after enactment.

(B) MCCA specified that its provisions relating to treatment of income and resources of institutionalized spouses superseded any contrary provision in the law relating to section 209(b) States. However, MCCA also left in place an existing provision relating to 209(b) States that could potentially be construed as allowing them to continue using more restrictive standards. Effective as if included in MCCA.

(C) MCCA limited the extent to which resources of an individual remaining in the community are deemed to be available for the care of a spouse entering a nursing facility for the purpose of determining the institutionalized spouse's Medicaid eligibility. When one member of the couple begins a continuous period of institutionalization on or after October 1, 1989, the total resources of both members are assessed and allocated to the community and institutionalized spouses according to formulas established by the Act.

House bill (section 4276(k))

(A) Applies the restriction on eligibility after a transfer of assets to cases in which the transfer was made by the spouse of the institutionalized person.

(B) Modifies the potentially conflicting provision relating to section 209(b) States to clarify that they are subject to the new MCCA standards.

(C) Provides that the assessment and allocation of a couple's resources is to occur only at the beginning of the first continuous period of institutionalization beginning after September 30, 1989.

Senate amendment

No provision.

Conference agreement

The conference agreement includes items (B) and (C) of the House bill. The agreement also clarifies that rules for treatment of income set forth in section 1924(b) of the Social Security Act apply after the institutionalized spouse has been determined to be eligible for Medicaid, and with respect to all subsequent redeterminations of eligibility, regardless of any State laws relating to community property or the division of marital property.

*(12) State utilization review systems**Present law*

OBRA 86 prohibited the Secretary from promulgating regulations requiring States to establish mandatory second surgical opinion programs or inpatient hospital preadmission review until 180 days after the Secretary submitted to the Congress a report on the extent to which such programs impede access to care and a variety of related issues concerning Medicaid beneficiaries' access to high volume or high cost procedures. The report was submitted in June 1989. The Administration's FY 1990 budget proposal indicated that the Administration plans to proceed with requirements that States implement second opinion and preadmission review programs, and also plans to require that States implement two additional utilization control approaches. The first would require substitution of ambulatory and same-day surgery for inpatient surgery. The second would require that medical tests ordinarily performed at the start of an inpatient hospital admission be performed on an outpatient basis before the admission.

House bill (section 4276(l))

Makes permanent that prohibition against requiring States to establish mandatory second surgical opinion or preadmission screening programs. Requires the Secretary to report to Congress by January 1, 1992, for a representative sample of States, an analysis of procedures for which ambulatory or same-day surgery or preadmission testing are appropriate for Medicaid patients, and the effects of such programs on access, quality, and costs. Prohibits the Secretary from promulgating regulations requiring States to implement such programs until 180 days after submitting the report.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill.

*(13) Health insuring organizations**Present law*

Before 1986, certain HMO-like entities known as "health insuring organizations" (HIOs) were determined by the Secretary to be exempt from statutory requirements for Medicaid HMO contractors, such as the 75 percent limit on Medicare/Medicaid enrollment and the requirement that enrollees be permitted to disenroll without cause. COBRA subjected HIOs to the HMO requirements, but allowed a temporary continuation of contracts with HIOs that were under development or operational on January 1, 1986, and for which the Secretary had granted Medicaid waivers under Section 2175 of OBRA 81.

House bill (section 4276(m))

Exempts up to 3 county-operated HMOs designated by the State of California from statutory requirements for Medicaid HMO contracts. The HIOs must be subject to California's own regulatory system for prepaid plans, must enroll all the Medicaid beneficiaries in the county (except qualified Medicare beneficiaries), must assure a reasonable choice of providers, and must comply with the requirements for payment adjustments for disproportionate share hospitals. The exemption applies only if the HIOs enroll no more than 10 percent of all Medicaid beneficiaries in California (not counting qualified Medicare beneficiaries).

Requires the Secretary to continue to waive the 75 percent Medicare/Medicaid enrollment limit for the Tennessee Primary Care Network, Inc., until June 30, 1992, under the same terms that applied to the waiver as of July 1, 1989.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House bill extension of the waiver of the 75 percent enrollment limitation for the Tennessee Primary Care Network.

*(14) Day habilitation and related services**Present law*

Among the optional Medicaid benefits a State may provide are clinic services and habilitation services. Some States have used one or the other of these options to provide day habilitation services to mentally retarded beneficiaries.

House bill (section 4276(n))

Prohibits the Secretary from denying Federal funding for day habilitation and related services if such services were an approved part of a State's Medicaid plan on or before June 30, 1989, and prohibits withdrawal of Federal approval of such a State plan provision, unless the Secretary promulgates regulations, with opportunity for public comment, specifying the types of day habilitation and related services a State may cover and any requirements applicable to those services. Provides that, if the Secretary promulgates such regulations, the Secretary may determine that a State's plan is not in compliance; however, the determination would apply only to services furnished on or after the first day of the first quarter following notice to the State of the determination and its basis.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House bill.

SUBTITLE C—MATERNAL AND CHILD HEALTH BLOCK GRANT PROGRAM

1. Increase in Authorization of Appropriations

Section 4301 of the House bill.

(A) AUTHORIZATION

Present law

The Maternal and Child Health Services Block Grant, under Title V of the Social Security Act, supports activities, through formula grants to the States and project grants, to improve the health status of mothers and children. Appropriations of \$561 million are authorized for the program for FY 1989 and each year thereafter.

House bill

Authorizes \$661 million for FY 1990 and each fiscal year thereafter to improve the health of all mothers and children consistent with the applicable health status goals and national health objectives established by the Secretary under the Public Health Service Act for the year 2000.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House bill with a modification to authorize \$686 million for FY 1990 and each fiscal year thereafter.

(B) USE OF FUNDS BY STATES

Present law

Funds are used for the purpose of enabling States—

(A) to assure mothers and children (particularly those with low income or with limited availability of health services) access to quality maternal and child health services;

(B) to reduce infant mortality and the incidence of preventable diseases and handicapping conditions among children, to reduce the need for inpatient and long-term care services, to increase the number of children appropriately immunized and the number of low income children receiving health assessments and follow-up diagnostic and treatment services, and otherwise to promote the health of mothers and children (especially by providing preventive and primary care services for low income children, and prenatal, delivery, and postpartum care for low income mothers);

(C) to provide rehabilitation services for blind and disabled individuals under age 16 receiving benefits under Title XVI of the Social Security Act; and

(D) to provide services for locating, and for medical, surgical, corrective, and other services, and care for, and facilities for diagnosis, hospitalization, and aftercare for, children who are "children with special health care needs" or who are suffering from conditions leading to such status.

House bill

Amends some provisions on services a State may provide to groups and individuals. Authorizes funds to be used to provide, as well as assure, access to quality services. Authorizes rehabilitation services for blind and disabled children under age 16 to be provided to the extent that medical assistance for such services is not provided under Medicaid.

For services for children with special health care needs, authorizes States to provide and promote family-centered, community-based, coordinated care (including care coordination services) for children with special health care needs and to facilitate the development of community-based systems of services. Defines "care coordination services" to mean services to promote the effective and efficient organization and utilization of resources to assure access to necessary comprehensive services for children with special health care needs and their families.

Senate amendment

No provision.

Conference agreements

The conference agreement includes the House bill.

(C) FEDERAL SET-ASIDES

Present law

Up to 15% of appropriated funds are set aside to enable the Secretary to provide for—

- (A) special projects of regional and national significance (SPRANS); (B) research, and training with respect to maternal and child health and children with special health care needs;
- (C) genetic disease testing, counseling, and information devel-

opment and dissemination programs; and (D) grants relating to hemophilia.

House bill

Retains set-aside for SPRANS, maternal and child health training and research, genetic diseases, and hemophilia grants. Provides that maternal and child health training and research for children with special health care needs will include early intervention training and services development. Provides that grants relating to hemophilia will include funding for comprehensive hemophilia diagnostic and treatment centers.

Authorizes a new set-aside to enable the Secretary (through grants, contracts, and otherwise) to provide for developing and expanding each of the following:

(A)(i) maternal and infant health home visiting programs, in which, among other services, case management services are provided in the home;

(ii) integrated maternal and child health service delivery systems;

(iii) maternal and child health centers operated under the direction of a not-for-profit hospital; and

(iv) projects designed to increase the participation of obstetricians and pediatricians under Title V and under State plans approved under the Medicaid program; and

(B)(i) projects for the screening of newborns for sickle cell anemia and other genetic disorders and follow-up services; and

(ii) maternal and child health projects to serve rural populations.

Defines "case management services" as used in this section to mean (A) with respect to pregnant women, services to assure access to quality prenatal, delivery, and postpartum care; and (B) with respect to infants up to age one, services to assure access to quality preventive and primary care services.

Senate amendment

No provision.

Conference agreement.

The conference agreement includes the House bill with a modification to include within the projects to be funded through the 15% secretarial set-aside, projects for the screening of newborns with sickle cell anemia and other genetic disorders and follow-up services.

In addition, the conference agreement establishes a new Federal set-aside to support (A) maternal and infant home visiting programs; (B) projects designed to increase the participation of obstetricians and pediatricians under both the MCH Block Grant and Medicaid programs; (C) integrated maternal and child health service delivery systems; (D) maternal and infant centers operated under the direction of not-for-profit hospitals; (E) maternal and infant child health projects to serve rural populations; and (F) outpatient and community based services programs for children with special health care needs. Funds would not be made available to support these programs and projects, however, until the level of ap-

appropriations for the Title V program exceeds \$600 million. Once that level is achieved, the conference agreement provides that 12.75 percent of the amount of funds appropriated above \$600 million is to be retained by the Secretary for the purpose of carrying out the activities ((A) through (F)) specified above. Of the balance remaining (after the Secretary has retained 12.75 percent of the funds appropriated above \$600 million), 85 percent is to be allotted to the States and 15 percent is to be retained by the Secretary, in accordance with the requirements of the Title V program.

The conference agreement further provides that the Secretary may conduct up to four demonstration projects to provide health insurance coverage (as defined by the Secretary) through eligible plans to medically uninsurable children (as defined by the Secretary). Such plans include those that are (A) school-based; (B) operated under the auspices of not-for-profit entities offering health insurance; and (C) operated by not-for-profit hospitals. Projects may only be conducted under an agreement with the Secretary which among other requirements, must provide that an eligible plan will provide health insurance coverage for at least two years and that the Secretary will guarantee such coverage if an eligible plan fails to meet this mandate. Under the conference agreement, these demonstration projects are authorized at a funding level of \$5 million for each of fiscal years 1991, 1992, and 1993.

2. Allotments to States and Federal Set-Asides

Section 4302 of the House bill.

Present law

Funds appropriated under the MCH block grant are allocated in accordance with the following formula: Of the amount appropriated each year, at least 10 percent and not more than 15 percent is retained by the Secretary for SPRANS, maternal and children training and research, genetic disease projects, and hemophilia grants. In those years in which the appropriation exceeds \$478 million, the Secretary retains an additional 9 percent of fund projects for screening of newborns for sickle cell anemia and other genetic disorders. Two-thirds of the balance of the amount exceeding \$478 million after the 9 percent set-aside is allocated are used by the Secretary for additional SPRANS projects and by the States for various maternal and child health services. One-third is allocated to the Secretary and to the States for primary care services for children, and for community-based service networks and case management services for children with special health care needs.

House bill

Authorizes changes in the allocation formula. Requires that a full 15 percent of the appropriation be allocated for the original SPRANS and related set-aside projects. Authorizes an additional 12.75 percent of the appropriation to be allocated for the new infant mortality, newborn genetic screening, and rural services set-aside. Provides that two-thirds of the funds in this set-aside will be used to support infant mortality initiatives and one-third will be

targeted for newborn genetic screening projects and maternal and child health programs in rural areas.

Provides that preference for project support for infant mortality initiatives will be given to applicants which demonstrate that project activities will be carried out in areas with higher than average infant mortality rates. Requires that funds will not be provided for developing or expanding a maternal and child health center under this set-aside without assurances of the provisions of non-Federal funds at least equaling the Federal grant support. Provides that at least 25 percent of the amount targeted in the new set-aside for newborn genetic screening projects and for rural projects must be used for each.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House bill with modifications regarding the establishment of a new Federal set-aside as specified in section (1)(c) above.

3. Use of Allotment Funds

Section 4303(a) of the House bill.

Present law

States may use MCH block grant funds for the provision health services and related activities (including planning, administration, education, and evaluation).

House bill

Provides that States may use MCH block grants funds for payment of salaries and other related expenses of National Health Service Corps personnel. Limits the amount of a State's block grant allocation that can be used for administration of its program to not more than 10 percent.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House bill.

4. Application for Block Grant Funds

Section 4303(b) of the House bill.

Present law

In order to receive their MCH block grant funds, States must submit to the Secretary a report that describes their intended use of the payments, and a statement of assurances that is designed to certify States' compliance with certain specified conditions.

House bill

Requires that States, in order to receive MCH block grant funds, submit an application (in a standardized form specified by the Secretary). Requires the application to be developed by, or in consultation with, the State MCH agency and be made public for comment during its development and after its transmittal.

Requires that States use at least 30 percent of their block grant allotments for preventive and primary care services for pregnant women, mothers, and infants up to age one; 30 percent for preventive and primary care services for children; and at least 30 percent for services for children with special health care needs. Provides for a waiver of this allocation if the Secretary determines that (A)(i) on the basis of its most recent annual report to the Secretary, the State has demonstrated, in its application, an extraordinary unmet need for services for one of the designated classes of individuals; (ii) the granting of a waiver is justified and will assist in carrying out the purposes of the block grant; and (B) the State provides assurances that each class of individuals will receive some services and specifies the percentages that are to be substituted for those mandated.

Requires that each State's application specify the State's block grant goals and objectives consistent with the health status goals and national health objectives for the year 2000. Requires that applications specify the information that States will collect in order to prepare annual reports. (See Item #5, below.)

Provides for application standards that relate to the Medicaid program, ensuring coordination of activities among Medicaid, the MCH block grant, and other related Federal programs. Requires State MCH block grant agencies to provide for services to identify pregnant women and infants eligible for services under the State's Medicaid program and to assist them in applying for Medicaid assistance. Requires each provider or practitioner providing health care services under the block grant to enter into a participation agreement to deliver services to individuals entitled to care under a State's Medicaid plan.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House bill with a modification to require that State applications contain a statewide needs assessment (to be conducted every five years) that identifies (consistent with the applicable health status goals and national health objectives established by the Secretary for the year 2000) the need for (A) preventive and primary care services for pregnant women, mothers, and infants up to age one; (B) preventive and primary care services for children; and (C) services for children with special health care needs. The conference agreement further requires that State applications include (for each fiscal year for which an application is submitted) a plan for meeting the needs identified by the statewide needs assessment as well as a description of how the

State intends to use its block grant funds for the provision and coordination of services to carry out such a plan.

The conference agreement also includes a modification to require States to use at least 30 percent of their block grant funds for preventive and primary care services for children and at least 30 percent of their block grant funds for children with special health care needs. The remaining 40 percent of funds is to be dedicated—at the State's discretion—to either of these groups or to other appropriate maternal and child health services, including preventive and primary care services for pregnant women, mothers, and infants up to age one.

In addition, the conference agreement provides that States must maintain the level of funds which they provided solely for maternal and child health programs in FY 1989. Under the conference agreement, States must also provide for a toll-free telephone number (and other appropriate methods) for the use of parents to obtain information about health care providers and practitioners participating in either the Title V or Medicaid program as well as information on other relevant health and health-related providers and practitioners.

5. State Reports

Section 4304(a) of the House bill.

Present law

Each State is required to prepare and submit to the Secretary annual reports on its activities under the Title V program.

House bill

Requires that each State's report be prepared by, or in consultation with, the State MCH agency; that the report be prepared and submitted for review in such standardized form as specified by the Secretary; and include a description of the extent to which the State has met the goals and objectives set forth in its block grant application.

Requires that State annual reports on the block grant contain certain information and data, as follows:

(A) Number of individuals (by class of individuals: pregnant women, infants up to age one; children with special health care needs; other children under the age of 2; and other individuals) served under Title V; the proportion of each class of such individuals with health coverage; the types of services provided to individuals in each class; and the amounts spent under Title V on each type of services, by each class of individual served;

(B) Information on the status of maternal and child health in the State, including information (by county, and by racial and ethnic group) on the rate of infant mortality and the rate of low birth weight births; information (on a statewide basis) on maternal mortality, neonatal deaths, perinatal deaths, infants born with fetal alcohol syndrome, infants born with drug dependency, the proportion of women who do not receive prenatal care during their first trimester of pregnancy, and the proportion of children who, at their second birthday, have been

vaccinated against measles, mumps, reubella, polio, diphtheria, tetanus, pertussis, Hib meningitis, and hepatitis B; and information on such other indicators of maternal, infant, and child health care status as the Secretary may specify;

(C) Information (by racial and ethnic group) on the number of deliveries in the State in the year, and the number of deliveries to such pregnant women who were provided prenatal, delivery, or postpartum care under the MCH block grant or who were entitled to benefits with respect to such deliveries under the Medicaid State plan in the year;

(D) Information (by racial and ethnic group) on the number of infants under one year of age who were in the State in the year, and the number of such infants who were provided services under the MCH block grant or were entitled to benefits under the Medicaid State plan at any time during the year; and

(E) Information on the number of obstetricians, family practitioners, certified family nurse practitioners, certified nurse midwives, pediatricians, and certified pediatric nurse practitioners who were licensed in the State in the year.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House bill with a modification to require States to include within their annual report, information (by county and by racial and ethnic group) on the number of children in the State with chronic illness and the type of illness.

6. Secretarial Report

Section 4304(b) of the House bill.

Present law

The Secretary is required to report annually to the Congress on activities funded under the SPRANS set-aside.

House bill

Requires the Secretary to report annually to the House Committee on Energy and Commerce and the Senate Committee on Finance. Requires the report to include a description of the projects funded under the two set-asides; a summary of the information provided by the States in their annual reports to the Secretary; a compilation of maternal and child health indicators based on the data supplied by the States to the Secretary; information on the number of pregnant women and infants receiving services under either the MCH block grant or Medicaid programs; and an assessment of the progress being made to meet the health status goals and national health objectives for the year 2000.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House bill.

7. Federal Assistance in Data Collection Mechanisms

Section 4305 of the House bill.

Present law

The Secretary is required to designate an administrative unit to be responsible for MCH block grant support activities, including technical assistance to the States in such areas as program planning, establishment of goals and objectives, standards of care, and evaluation.

House bill

Includes in areas of technical assistance provided to the States the development of consistent and accurate data collection mechanisms to comply with the new annual reporting requirements.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House bill with a modification to include among the Federal Bureau of Maternal and Child Health's support activities, assistance to the States in the development of care coordination activities. In addition, the conference agreement provides that the Federal MCH Bureau shall develop and make available to State Title V agencies, a national directory which lists the toll-free telephone numbers States are required to provide for the use of parents to access information about health and health-related providers and practitioners. (See Item #4, above.)

8. Development of Model Application Form for Maternal and Child Assistance Programs

Section 4306 of the House bill.

Present law

No provision.

House bill

Requires the Secretary to develop and disseminate within one year of the date of enactment (in consultation with the Secretary of Agriculture) a model application form for use in applying, simultaneously, for assistance for a pregnant women or a child under age 6 under the following maternal and child assistance programs: the MCH block grant, Medicaid, the migrant and community health centers programs under sections 329 and 330 of the Public Health Service Act, the grant for the homeless under section 340 of the Public Health Service Act, the WIC program of the Child Nutrition Act of 1966, and the Head Start program. In developing such a

form, the Secretary may not change any requirement with respect to eligibility under any of the programs.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House bill with a modification to require that the Secretary also develop, within one year after enactment, a model application form for use in applying for Medicaid benefits by non-institutionalized individuals. Such model application form is to be published in the Federal register and is to be distributed to each State agency responsible for administering the Medicaid program. Under the conference agreement, however, States may not be required to adopt the model application form as part of their State Medicaid plans.

The conference agreement includes an additional modification to require the Secretary to develop and make available to pregnant women and families with young children, a maternal and child health handbook. Under the conference agreement, the handbook is to be made available through public programs such as maternal and child health clinics (supported through either the block grant or the Medicaid program), community and migrant health centers, WIC clinics, Head Start, and the grants projects for the homeless, and is to be targeted on high-risk women.

9. Research on Infant Mortality and Medicaid Services

Section 4307 of the House bill.

Present law

No provision.

House bill

Requires the Secretary, through the National Center for Health Statistics, to develop a national system for linking, for any infant up to age one, the infant's birth record; any death record for the infant; and information on any claims submitted under Medicaid for health care furnished to the infant or with respect to the birth of the infant.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House bill with a modification to require that the Secretary develop the national data system.

10. Effective Date

Section 4208 of the house bill.

House bill

Applies to fiscal years beginning FY 1990, except that provisions relating to State applications for block grant funds and to State and Secretarial reports on the block grant apply for fiscal years beginning with FY 1991.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House bill.

SUBTITLE D—VACCINE COMPENSATION TECHNICALS

A. Vaccine Compensation Technicals

VACCINE INJURY COMPENSATION TECHNICALS

Section 4402 of the House bill.

Present law

(a) *Petitions*.—The Vaccine Injury Compensation Program provides that a proceeding for compensation for a vaccine-related injury or death shall be initiated by service upon the Secretary and the filing of a petition with the U.S. Claims Court.

The Act provides that a petitioner with a civil action pending on the effective date of the Act concerning a vaccine-related injury or death may elect to withdraw the action without prejudice and enter the compensation system. Any such petitioner who does not withdraw an action is prohibited from entering the compensation system.

The Act requires a petition to contain, among other things, appropriate assessments, evaluations, and prognoses and other necessary records and documents for the determination of compensation to be paid.

(b) *Special masters*.—The Act provides for the designation of Special Masters with powers to require such evidence as may be needed to determine whether compensation should be awarded and if so, the amount of compensation to be awarded. The Act provides that the master may require the submission of relevant evidence and information, conduct hearings, and submit to the court proposed findings of fact and conclusions of law.

(c) *De novo proceedings*.—The Act provides that, upon objection by the petitioner or respondent to proposed findings of fact or conclusions of law by the special master or upon the court's own motion, the court shall undertake a review of the records of the proceedings and may thereafter make a de novo determination of any matter and issue its judgment accordingly, including findings of fact and conclusions of law, or remand for further proceedings.

(d) *Time for judgment*.—The Act requires the court to render its judgment on any petition filed under the Program as expeditiously as practicable but not later than 365 days after the date on which the petition was filed.

House bill

The House bill provides that the foreign tax credit limitation is applied separately with respect to any lump sum distribution on which the separate tax of section 402(e)(1) is imposed, and the amount of the distribution is treated as taxable income for purposes of computing the limitation.

The provision is effective as if included in the provision of the 1988 Act to which it relates.

Senate amendment

No provision.

Conference agreement

The conference agreement generally follows the House bill with the following modification to the effective date. Under the agreement, the provision is effective for taxable years ending after the date of enactment. Additionally, at the election of the taxpayer, the provision is effective for taxable years beginning after December 31, 1986. A taxpayer may exercise an election to utilize this provision for any such taxable year adjustments to which are not barred by the statute of limitations, by filing a tax return (or amended return) for such year, which return reflects the application of this provision.

O. CHILD CARE AND EARNED INCOME TAX CREDIT PROVISIONS

1. Expansion of the Title XX Social Services Block Grant for Child Care Services

*Present law**(a) Funding*

Title XX is a capped entitlement; funds are currently limited to \$2.7 billion annually. (Note: as part of its reconciliation bill, the House approved a separate increase in the entitlement ceiling; under the House bill, by 1993 the basic entitlement ceiling would reach \$3.3 billion.) Allotments to a State for a fiscal year must be expended in such fiscal year or the succeeding fiscal year. Generally, State allotments are based on State population.

There is no provision for reallocation of unused funds.

(b) Use of funds

Funds must be used to provide services directed at achieving five goals: preventing or reducing dependency; achieving self-sufficiency; preventing or remedying neglect, abuse or exploitation of children and adults; preventing or reducing inappropriate institutional care; and providing services or referrals to individuals in institutions. Services include, but are not limited to: child care, home care, protective services for children and adults, services for children and adults in foster care, adult day care, transportation, family planning, training, employment, counseling, meals, and health support. A majority of States use some Title XX funds to provide child care services.

(c) Child care reimbursement

No provision.

(d) Child care targeting provisions

No specific provision, although services must conform to the Title XX goals to reduce dependency, etc. States providing child care through the Title XX grant have established income eligibility guidelines for child care services.

(e) Reports

Before expending its Title XX allocation, each State must report on the intended uses of the payment. Annually, each State must report on the actual uses of the payment, including certain specific information such as the number of children and adults receiving services, the amount spent for each type of service per recipients, methods by which services are provided, and eligibility criteria.

(f) Child care standards

The Title XX grant may not be used by any State to provide child day care services unless they meet applicable standards of State and local law.

(g) State eligibility

No provision.

(h) Relative care issues

No provision.

(i) Training of child care providers

No provision.

Church/State issues

Title XX law does not contain language relating to Church/State issues. Under Title XX, States have chosen a variety of mechanisms to deliver child care services, including contracts and grants with providers, and vouchers. The choice of mechanisms is a State decision.

(k) Maintenance of effort for standards and licensing

No provision.

(l) Child care enforcement

No provision.

*House bill**(a) Funding*

The House bill would permanently increase funds for Title XX of the Social Security Act by \$200 million for fiscal year 1990, \$350 million for fiscal year 1991 and \$400 million for fiscal year 1992 and each subsequent year.

These additional funds would be earmarked for child care, are in addition to the basic increases approved by the House as part of the budget reconciliation legislation, and could not be used to sup-

plant Federal and State funds currently used for child care. These funds would bring the Title XX funding total to \$2.9 billion in fiscal year 1990, \$3.250 billion in fiscal year 1991, \$3.5 billion in fiscal year 1992, and \$3.7 billion in fiscal year 1993 and thereafter (assuming the basic Title XX increases proposed by the House are also approved). States would have two fiscal years to expend a given fiscal year allocation. The State agency with primary responsibility for child care would administer these funds.

Unexpended funds earmarked for child care would be reallocated to other States.

(b) Use of funds

States would be required to use 80 percent of the earmarked monies for child care services; the remaining 20 percent would be used for child care-related administration and training as well as enforcement of child care standards.

(c) Child care reimbursement

Child care expenses would be reimbursed at market rates, with higher reimbursements for infants and toddlers, children with disabilities, and comprehensive child care programs for children of adolescent parents.

(d) Child care targeting provisions

States would be required to establish a sliding fee schedule for the delivery of child care services and must assure that such services are provided at no cost to families with incomes below the poverty level.

(e) Reports

Before expending the allocation, the State must report to the Secretary on the intended uses of the payment, and must make the report public so as to facilitate public comment. The State must notify the Secretary of the amount of any payment which the State does not intend to expend. Annually, beginning for FY 1992, each State must report to the Secretary on the child care activities actually carried out with Title XX funds including both earmarked and unearmarked funds. The report must provide certain specific information showing separately for center-based, group home, family and relative child care services: by geographical area, the number of children receiving services, grouped by family income as a percent of the poverty line; the average cost and market rate of child care services; out-of-pocket costs for services by family income level as a percent of the poverty line; the criteria applied in determining eligibility or priority for receiving services; the methods of service provision; child care standards; licensing and regulatory requirements; and enforcement policies and practices.

The Secretary must establish uniform reporting requirements for use by the States.

(f) Child care standards

A State that receives funds earmarked for child care under title XX must, beginning three years after enactment, have in effect State child care standards that address all of the matters specified

below. The standards must apply to all Title XX-funded child care and to any child care services delivered by providers that receive public funds for child care services. The present law rule would apply to States that do not use any of the additional, earmarked funds in any year.

The categories for State child care standards would be the following:

(1) Center-based child care services

Group size limits in terms of the number of caregivers and number and ages of children;

Maximum appropriate child-staff ratios;

Qualifications and background of child care personnel;

Requirements for inservice training;

Health and safety requirements, including requirements for the prevention and control of infectious diseases (including immunization and hand washing procedures), injury prevention and treatment, building and physical premises safety, general health and nutrition, children with special needs, and prevention of child abuse; and

Requirements for parental involvement in licensed and regulated child care services.

(2) Family child care services

Maximum number of children and maximum number of infants for whom child care services should be provided;

Minimum age of caregivers;

Requirements for inservice training or participation in a provider organization that addresses child development and management issues; and

Health and safety requirements (including those described above for center-based child care services, as are appropriate for family child care services).

(3) Group home child care services

Maximum appropriate child staff ratios;

Maximum number of children and maximum number of infants for whom child care services should be provided;

Minimum age of caregivers;

Requirements for inservice training or participation in a provider organization that addresses child development and management issues; and

Health and safety requirements (including those described above for center-based child care services, as are appropriate for group home child care services).

Each provider who receives funds earmarked for child care under Title XX must also comply with all applicable State and local licensing or regulatory requirements (including registration requirements). The Committee does not consider child care to include camping.

(g) State eligibility

A State would be ineligible for the additional Title XX funds beginning three years after enactment unless it demonstrates that all Title XX-funded child care providers and all other providers that receive public funds for child care services are: (1) licensed or regulated as required by State and local law; (2) satisfy any applicable State standards; and (3) are subject to certain enforcement provisions (see below).

(h) Relative care issues

There would exist no requirement, or mandate on the States to require, the training or licensing of individuals who provide child care solely to members of their families.

(i) Training of child care providers

Beginning two years after enactment, any State that receives the earmarked Title XX funds must require that all Title XX child care providers and any other child care providers that receive any public funds for child care services, and the caregivers employed by such providers, complete an average of 15 hours of training annually. Such training must be tailored to the needs of the State and providers.

(j) Church/State issues

Retains current law; i.e., no language.

(k) Maintenance of effort for standards and licensing

The State may not reduce the categories of child care providers licensed or regulated by the State on the date of enactment, or reduce the level of standards applicable to child care services provided in the State, unless the State demonstrates, to the satisfaction of the Secretary, that the reduction is: (1) based on positive developmental practice; or (2) necessary to increase access to and availability of child care providers and will not jeopardize the health and safety of children.

(l) Child care enforcement

Not later than three years after enactment, the State must have in effect enforcement policies and practices that would apply to all child care funded under Title XX and all child care services delivered by providers who receive public funds for child care services, including certain specific policies and practices that:

(1) Require personnel who perform inspection functions to receive training in child development, health and safety, child abuse prevention and detection, the needs of children with a disability, program management, and relevant law enforcement;

(2) Impose personnel requirements to ensure that individuals who are hired as licensing inspectors are qualified to inspect and, to the maximum extent feasible, have inspection responsibility exclusively for children's services;

(3) Require personnel who perform inspection functions to make (a) not less than 1 unannounced inspection annually of

each center-based child care provider in the State; and (b) unannounced inspections annually, and during normal hours of operation, of not less than 25 percent of licensed and regulated family child care providers in the State;

(4) Require the ratio of licensing personnel to child care providers in the State to be maintained at a level sufficient to enable the State to conduct inspections on a timely basis;

(5) Require licensed or regulated child care providers (including registered providers) to (a) have written policies and program goals and to make a copy of such policies and goals available to parents, and (b) provide parents with unlimited access to their children;

(6) Implement a procedure to address complaints that will provide a reasonable opportunity for a parent or provider that is adversely affected by a decision to be heard by the State;

(7) Prohibit the operator of a facility to take any action against an employee that would adversely affect the employment, or terms or conditions of employment, of such employee because such employee communicates a failure of the operator to comply with any applicable licensing or regulatory requirement;

(8) Make consumer education information available to inform parents and the general public about licensing requirements, complaint procedures, and required policies and practices;

(9) Require a provider to post, on the premises where child care services are provided, the telephone number of the appropriate licensing or regulatory agency that parents may call regarding a failure of the provider to comply with any applicable licensing or regulatory requirement; and

(10) Require the State to maintain a record of parental complaints and to make information regarding substantiated parental complaints available to the public on request.

(m) Effective date

The provision is effective beginning fiscal year 1990.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill provision. The conferees intend that an extension of the telephone excise tax shall be the exclusive and only required source of funding of child care legislation that may be enacted in the second session of the 101st Congress, except to the extent that the costs of such legislation exceed the costs of the child care provisions contained in Title XI of the House-passed reconciliation bill. It is the intent and understanding of the conferees that the revenues contained in this reconciliation bill are sufficient to cover any costs in excess of the telephone excise tax. The fencing off of these revenues does not prejudice in any way the substance or structure of the child care package.

2. *Child Care Standards Improvement Incentive Grant and Demonstration Project*

Present law

No provision.

House bill

(a) Child care standards improvement incentive grant program

Beginning with fiscal year 1990, the House bill would authorize a Child Care Standards Improvement Incentive Grant Program to assist States in improving child care standards. To be eligible to receive a grant, a State must provide:

(1) Assurance that the State will not require any private provider receiving Title XX funds to contribute in cash or kind to the required State share;

(2) Information describing the present level of standards in effect in the State, the prospective use of the grant, and the expected improvement in standards of the State;

(3) Assurance that the State will use any amounts received to specifically improve its child care standards; and

(4) Any other information that the Secretary determines appropriate.

The Secretary would award initial grants after considering the following criteria:

(1) The relative quality of the existing standards of the State in comparison to the standards of other States submitting applications;

(2) The level of standards that the State desires to adopt and the State plans for achieving this improved level; and

(3) The relative fiscal capacity of the State in comparison to other States submitting applications.

Subsequent grants would be awarded based on the compliance of a State with the application for the previous grant.

The amount of the grant would be equal to 80 percent of the costs to be incurred. Each State awarded a grant must pay 20 percent of the costs from non-Federal sources. Grants would be for a 2-year period with no State receiving more than 3 consecutive grants.

(b) Child development systems demonstration program

Also beginning in fiscal year 1990, the Secretary would be authorized to make grants for a Child Development Systems Demonstration Program. Under the program, grants would be made annually to not more than 10 eligible public or private entities, in urban and rural areas, to administer child development systems in which high quality child development centers become a mentor for a network of smaller community centers and family day care providers for the purpose of improving the quality of child care and assuring greater continuity and parental involvement.

Public agencies or private entities that apply must submit an application containing:

(1) Information demonstrating that the applicant has established, or will establish, a child development model;

(2) A detailed plan for recruiting, training, and supporting family child care satellites that will participate in the model;

(3) An assurance that each family child care satellite will be required (a) to pay the applicant a minimal annual fee, and (b) to enter into a contract with the applicant requiring the satellite to provide high quality child care services;

(4) A detailed plan for the continuing evaluation of the model and its satellites;

(5) A plan specifying in detail the expenditures the applicant will make, as part of administering a child development model, with the grant throughout a 2-year period.

(6) An assurance that resource materials acquired by the model will be made available to any child care provider in the community;

(7) An assurance that at least 1 participating satellite will provide services to (a) children who are ill but not terminally ill, (b) children who do not speak English as their primary language if there is a reasonable number of such children in the geographical area of the model, and (c) children who have a handicapping condition;

(8) An assurance that the applicant will recruit, train, monitor, and provide support for not fewer than 20 and not more than 35 family child care satellites;

(9) An assurance that the applicant will provide each satellite training with respect to (a) basic child development, (b) developmentally appropriate activities, (c) developmentally appropriate problem solving, and (d) providing family child care services as a business; and

(10) Information describing the demographics of the population in the geographical area.

Each grantee must evaluate each family child care satellite that participates in the model, including:

(1) A determination, based on making monthly visits (with and without advance notice) whether (a) the child care services are appropriate for the ages of the children, (b) the interaction of the staff with children is of good quality, and (c) the satellite is providing nutritional food to satisfy the needs of the children;

(2) A determination of the extent to which the community cluster of which the model is a part (a) expands the availability of quality child care for working families, (b) encourages quality and professionalism in child care, (c) encourages the emotional security of sustained relationships between children and child care providers, (d) serves as a model and information center for current and potential child care providers, and (e) educates family child care providers on matters relating to quality child care; and

(3) Such other information as the Secretary requires.

Expenditures of \$75 million annually would be authorized for the Child Care Standards Improvement Incentive Grant Program, of which 2 percent would be earmarked for the Child Development Systems Demonstration Program. The authorization would extend

through fiscal year 1998. The Federal matching rate would be 80 percent.

(c) Effective date

The provision is effective beginning in fiscal year 1990.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill provision.

3. Expansion of the Earned Income Tax Credit

Present law

An individual who maintains a home for one or more children is allowed an advance refundable tax credit based on the taxpayer's earned income (sec. 32 of the Code). In 1989, the earned income credit (EITC) is equal to 14 percent of the first \$6,500 of earned income. The credit is phased out at a rate of 10 percent of the amount of adjusted gross income (or, if greater, the earned income) that, in 1989, exceeds \$10,240. The \$6,500 and \$10,240 amounts are adjusted annually for inflation, so that the maximum amount of credit and the maximum amount of income eligible for the credit increase with inflation.

Eligibility

The credit is available to: (1) married individuals filing a joint return who are entitled to a dependency exemption for a child, (2) a head of household, or (3) a surviving spouse. In order to be eligible to claim a dependency exemption, the taxpayer, in general, must provide over half of the support for the child, and the child must have the same principal place of abode as the taxpayer for a least half the year. Benefits under the Aid to Families with Dependent Children (AFDC) and other public assistance program are not considered support provided by the taxpayer. Thus, if more than half of the taxpayer's income is from AFDC or sources other than the taxpayer's own income, the earned income tax credit generally is not available.

Advance payment

An employee may elect to furnish a certificate of eligibility for the earned income tax credit to his or her employer. Every employee for whom a certificate is in effect must receive, at the time that wages are paid, an additional advance payment of the earned income credit. A certificate of eligibility has effect only for one calendar year and a new certificate must be filed annually to continue receipt of advance payments.

Treatment of credit for means-tested programs

The amount of the earned income tax credit is not treated as income for purposes of determining eligibility for benefits under the AFDC program or for certain other means-tested programs.

Effective date

The provisions are generally effective for taxable years beginning after December 31, 1990.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill provision.

TITLE VIII—HUMAN RESOURCE AND INCOME SECURITY PROVISIONS

For explanatory matter with respect to Title VIII of the conference report, refer to Subtitle C, Title X, of the Joint Statement of Managers.

TITLE IX—OFFSHORE OIL POLLUTION COMPENSATION FUND

Senate bill

Title III of the Outer Continental Shelf Lands Act Amendments of 1978 (OCSLAA) establishes the Offshore Oil Pollution Compensation Fund to assist in clean-up in the event of an oil spill associated with OCS operations. The Fund is supported by a charge of three cents per barrel of oil produced on OCS lands. The law provides for maintenance of a threshold balance within the fund of \$100,000,000 and a ceiling of \$200,000,000. The Secretary of Transportation suspended collection of payments to the Fund earlier this year when the balance was \$133,300,000.

Section 4201 of the Senate amendment amends Title III of the OCSLAA to require maintenance of the Fund at \$200,000,000. Reimposition of the three cent per barrel charge would occur at any time the balance in the Fund drops below that level.

House bill

The House bill contains no comparable provision.

Conference agreement

The House recedes to the Senate provision.

TITLE X—OUTLAY AND REVENUE PROVISIONS

SUBTITLE A—SOCIAL SECURITY ADMINISTRATION, OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE, AND RAILROAD RETIREMENT

1. *Establishment of the Social Security Administration (SSA) as a Separate and Independent Agency*

Sections 10001-10014 of the House bill.

Present law

a. Status of agency.—SSA is a component of the Department of Health and Human Services (HHS).

b. Agency leadership and management.—The Secretary of Health and Human Services (HHS) has responsibility for administration of the OASDI and SSI programs. Administration of these programs has been delegated to the Commissioner of Social Security. The Commissioner reports only to the Secretary.

c. Deputy Commissioner of Social Security.—Under current SSA practice, there are four deputy commissioners (for management, operations, policy and external affairs, and programs) and a chief financial officer who serve under the commissioner. None of these are statutory positions. None of the deputy commissioners is designated to serve as acting commissioner in the absence of the Commissioner.

d. General counsel.—SSA receives legal services from the Office of General Counsel of HHS through a component headed by a Chief Counsel for Social Security.

e. Inspector general.—The Inspector General of HHS is responsible for oversight of SSA.

f. Beneficiary ombudsman.—No formal position of this nature exists within SSA.

g. Administrative law judges.—The Social Security Act requires SSA to conduct hearings to consider appeals of SSA decisions by recipients. These hearings are conducted by administrative law judges (ALJs). Although not required by law, the agency follows the procedures of the Administrative Procedures Act (APA) with respect to the appointment of ALJs and the conduct of hearings. The ALJs are located organizationally within the Office of Hearings and Appeals, headed by an associate commissioner who reports to the Commissioner of SSA.

h. Interim authority of the Commissioner.—No provision.

i. Personnel; budgetary matters; facilities and procurement; seal of office.—No provision.

j. Transfers and transitional rules.—No provision.

House bill

a. Status of agency.—SSA would be made an independent agency in the executive branch of the Government, with responsibility for administration of the Old Age, Survivors, and Disability Insurance (OASDI) and Supplemental Security Income (SSI) programs.

b. Agency leadership and management.—SSA would be governed by a three-member, full-time Board, appointed by the President with the advice and consent of the Senate, and would serve 6-year terms, with no more than two members being from the same political party. Board members could be removed from office by the President only pursuant to a finding of neglect of duty or malfeasance in office. The terms of the first members would expire on June 30, 1993; June 30, 1995; and June 30, 1997.

Recommendations for persons to serve on the Board would be made by the Chairmen of the House Ways and Means and the Senate Finance Committees. A member may, at the request of the President, serve for up to a year after the member's term expires until a successor has taken office. A member can be appointed for additional terms.

The President would appoint one of the members to be chairperson of the Board for a 4-year term. The chairperson or two mem-

bers could call a meeting of the Board with any two members constituting a quorum. Any member alone may hold a hearing.

Each member of the Board would be compensated at the rate provided in level II of the Executive Schedule. No member may engage in any other business, vocation, profession, or employment.

The Board would:

- Govern OASDI and SSI by regulation;

- Establish the Administration and oversee its efficient and effective operation;

- Establish policy and devise long-range plans;

- Appoint an Executive Director to act as the agency's chief operating officer;

- Constitute three members of a new 7-member Board of Trustees of the social security trust funds, with the chairperson of the agency's Board serving as chairperson of the Board of Trustees (the Secretary of Labor would be dropped as a member of the Board of Trustees);

- Make annual budgetary recommendations and defend them before the appropriate committees of each House of Congress;

- Study and make recommendations to the Congress and President of the most effective methods of providing economic security through social insurance, SSI, and related programs and matters related to OASDI and SSI administration;

- Provide the Congress and President with ongoing actuarial and other analyses; and

- Conduct policy analysis and research.

The Board may prescribe rules and regulations. It may also establish, alter, consolidate, or discontinue organizational units and components of the agency. Further, it may assign duties and delegate (or authorize successive redelegations) to such officers and employees as it deems necessary.

An Executive Director would be appointed by the Board to serve as the agency's chief operating officer for a 4-year term (except that the individual first appointed would serve until September 30, 1995). The individual may serve up to one additional year until a successor has taken office (at the request of the chairperson of the Board), and may be appointed for additional terms. An Executive Director may be removed from office before completion of his or her term only for cause found by the Board. Compensation would be set at the rate provided in level II of the Executive Schedule.

The Executive Director would:

- Be the chief operating officer responsible for administration;

- Maintain an efficient and effective administrative structure;

- Implement the long-term plans of the Board;

- Report annually to the Board on the program costs of OASDI; make annual budgetary recommendations for the program costs of SSI and the administrative costs of SSI and OASDI; and defend budgetary recommendations before the Board;

- Advise the Board and Congress of effects on administration of proposed legislative changes;

- Serve as Secretary of the Board of Trustees (for OASDI);

Report to the Board in December of each year, for transmittal to Congress, on administrative endeavors and accomplishments; and

Carry out any additional duties as are assigned by the Board.

c. Deputy Director of Social Security.—A deputy director of social security would be appointed by and serve at the pleasure of the Executive Director.

The deputy would perform such duties and exercise such powers as are assigned by the Executive Director, and serve as acting executive director during the absence or disability of the Executive Director. The deputy would also serve as acting executive director in the event of a vacancy in the office of Executive Director unless the Board designates another official to fill this post. He or she would be compensated at the rate provided in level III of the Executive Schedule.

d. General counsel.—A General Counsel would be appointed by and serve at the pleasure of the Board as SSA's principal legal officer. He or she would be compensated at the rate provided in level IV of the Executive Schedule.

e. Inspector general.—An Office of Inspector General would be created within SSA, to be headed by an Inspector General appointed in accordance with the Inspector General Act of 1978. He or she would be compensated at the rate provided in level IV of the Executive Schedule.

f. Beneficiary ombudsman.—An Office of Beneficiary Ombudsman, headed by a beneficiary ombudsman appointed by the Board, would be created within SSA. The term of office would be 5 years, except for the first ombudsman whose term would end September 30, 1995. The ombudsman may serve up to one additional year until a successor has taken office (at the request of the chairperson of the Board), and may be appointed for additional terms. The ombudsman may be removed from office before completion of his or her term only for cause found by the Board. Compensation would be set at the rate provided in level V of the Executive Schedule.

The beneficiary ombudsman would:

- Represent the interests and concerns of program recipients within SSA's decision-making process;

- Review SSA's policies and procedures for possible adverse effects on recipients;

- Recommend within SSA's decision-making process changes in policies which have caused problems for recipients;

- Help resolve problems for individual recipients in unusual or difficult circumstances, as determined by the Administration; and

- Represent the views of recipients within SSA's decision-making process in the design of forms and the issuance of instructions.

The Board would assure that the Office of Beneficiary Ombudsman is sufficiently staffed in regional offices, program centers, and the central office.

The annual report of the Board would include a description of the activities of the beneficiary ombudsman.

g. Administrative law judges.—An Office of Chief Administrative Law Judge, headed by a chief ALJ appointed by the Board, would be created within SSA to administer the affairs of SSA's ALJs in a manner so as to ensure that hearings and other business are conducted in accordance with applicable law and regulations. The chief ALJ would report directly to the Board.

Notwithstanding any other provision of law, insofar as the requirements of section 205 of the Social Security Act apply to administrative appeal hearings under the Social Security Act, such hearings would be conducted by administrative law judges in the independent agency under procedures established by the Board acting as delegates of the Board or of the Secretary of HHS as appropriate. The Board would be required to consult with the Secretary of HHS on changes in procedures affecting such appeals. This provision would mean that certain hearings relating to Medicare would continue to be heard by SSA Administrative Law Judges.

The Secretary of HHS (in consultation with the Board) and GAO would be required to report to the House Ways and Means and Senate Finance Committees by July 1, 1992, on the appropriateness of maintaining this arrangement for appeal hearings.

h. Interim authority of the Commissioner.—The President would be required to nominate appointments to the Board not later than April 1, 1990. If all members of the Board are not in office by July 1, 1990, the person then serving as Commissioner of Social Security would continue to serve as head of SSA, assuming the powers and duties of the Board and the Executive Director.

i. Personnel; budgetary matters; facilities and procurement; seal of office.—The Board would appoint additional officers and employees as it deems necessary (with compensation fixed in accordance with title 5 of the U.S. Code), except as otherwise provided by law, and could procure services of experts and consultants. The Director of the Office of Personnel Management (OPM) would be required to give SSA an allotment of Senior Executive Service (SES) positions that exceeds the number authorized for SSA immediately before enactment of this Act to the extent a larger number is specified in a comprehensive work plan developed by the Board. The total number of such positions could not be reduced at any time below the number SSA held immediately before enactment of this Act.

SSA also would be authorized 6 additional positions at level IV and 6 additional positions at level V of the Executive Schedule (i.e., beyond those provided for the Inspector General and Beneficiary Ombudsman).

On a demonstration basis (as soon as practicable after June 30, 1990), the Board and the Director of OPM would be required to implement one or more projects (after consultation with the affected personnel and their union representatives):

Permitting the Board to hire technical and professional employees without regard to the appointment and classification criteria and GS pay rates contained in title 5 of the U.S. Code as it pertains to appointments (but not to permit pay rates above level IV of the Executive Schedule) and chapter 51 and subchapter III of chapter 53 of that title; and

Delegating functions to the Board relating to recruitment and examination programs for entry-level positions, and classi-

fication and standards development systems and pay ranges for those jobs. The Comptroller General would be required to evaluate the readiness of the Board to assume permanent and full authority over these personnel functions and report to the House Ways and Means and Senate Finance Committees by June 30, 1994.

On a demonstration basis (as soon as practicable after June 30, 1990), the Board and the Administrator of GSA would be required to implement one or more projects delegating GSA functions to the Board for acquisition, operation, and maintenance of SSA facilities (GSA would retain authority over SSA's procurement and maintenance of telecommunications and automatic data processing equipment and services). The Comptroller General would be required to evaluate the readiness of the Board to assume permanent and full authority over these facilities management functions and report to the House Ways and Means and Senate Finance Committees by June 30, 1994.

Appropriation requests for SSA would be based on staffing and personnel requirements set out in periodically-revised comprehensive work plans developed by the Board. The amounts appropriated would be apportioned for the entire period covered by the appropriations act by the Office of Management and Budget without restriction or deduction (except that funds for contingency purposes would be apportioned only upon the occurrence of the stipulated contingency).

The Board would create a Seal of Office for SSA, and judicial notice would be taken of it.

j. Transfers and transitional rules.—Appropriate allocations of personnel and assets (as determined by the Board in consultation with the Secretary of HHS) would be transferred from HHS to SSA, and all orders, determinations, rules, regulations, permits, contracts, collective bargaining agreements, recognitions of labor organizations, certificates, licenses, and privileges in effect at SSA at the time of the transition would remain in force at the agency until their expiration or modification in accordance with law. The transfer would not cause any full-time or part-time employee to be reduced in grade or compensation for one year after the transition, nor would the change alter any pending proceedings before the Secretary, suits, or penalties.

Effective date

In general, the provision would take effect July 1, 1990.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House provision.

2. Statement of Liabilities of the OASDI Trust Funds

Section 10041 of the House bill.

Present law

Section 201(c) of the Social Security Act requires the Trustees to report annually on the "actuarial status of the Trust Funds." An actuarial opinion by the Chief Actuary of SSA is required certifying that the techniques and methodologies used are generally accepted within the actuarial profession and that the assumptions used and the resulting actuarial estimates are reasonable. By practice, Trustees' reports have included long-range projections of income, outgo, the size of the Trust Funds over a 75-year period, and the overall average actuarial balance of the system covering 25, 50, and 75-year periods into the future, expressed as percentages of taxable payroll. Recently, the projected actuarial balance of the system has been calculated using "present values" of taxable payroll, income, and outgo. Although the Trustees' reports have included dollar-denominated projections of income and outgo, and the size of the Trust Funds for selected years in the future, they have not shown the actuarial balance of the system in measures other than as percentages of taxable payroll.

House bill

Generally, requirements for determining the "actuarial status of the Trust Funds" would be defined in the law using projection periods (25, 50, and 75 years), measures, and criteria similar to those used under current practice. In addition, the actuarial analysis contained in the annual Trustees' reports would include a measure of the present value of the actuarial balance of the system calculated in dollar-denominated terms (in addition to percentage of taxable payroll).

For purposes of the analysis, the language defines "present value actuarial balance for a Trust Fund" over a period of calendar years to be "the difference between (i) the sum of the actuarial present value of expected future income to the Trust Fund during the period and the assets of the Trust Fund at the beginning of the period and, (ii) the actuarial present value of expected future disbursements from the Trust Fund during the period."

Effective date

Applies to Trustees' reports required beginning with the year 1990.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House provision.

3. Elimination of Dependency Test Applicable to Certain Adopted Children

Section 10051 of the House bill.

Present law

A child adopted before a worker becomes entitled to retirement or disability benefits is eligible for child's insurance benefits. A

child (other than the worker's stepchild) adopted after a worker's entitlement is ineligible for social security benefits unless he or she was living with the worker, and dependent upon the worker for one-half of his or her support, for the year prior to the worker's entitlement.

House bill

A minor child adopted after a worker becomes entitled to retirement or disability benefits would be eligible for child's benefits regardless of whether he or she was living with and dependent upon the worker prior to the worker's entitlement.

Effective date

Applies with respect to benefits payable for months after December 1989, but only on the basis of applications filed on or after January 1, 1990.

Senate amendment

No provision.

Conference agreement

The conference follows the House provision.

4. Clarification of Rules Governing Taxation Under FICA and SECA of Individuals of Certain Religious Faiths

Section 10052 of the House bill.

Present law

Self-employed workers may claim an exemption from social security coverage if (a) they are members of a religious sect or division that is conscientiously opposed to the acceptance of public or private insurance benefits, (b) they have waived all benefits under social security and medicare, (c) the sect or division has been in existence since December 31, 1950, and (d) the sect or division provides for the care of its dependent members. In addition, in cases where a self-employed individual has employees and both employer and employee meet the conditions described above, the employee may claim an exemption from social security coverage. This optional exemption applies to both the employer and employee portions of the social security tax. However, individuals who are employed by a church (or church-controlled organization), but are treated as self-employed under a separate provision of law, may not claim the exemption from social security coverage.

House bill

The religious exemption would be extended in two ways. First, it would be available to employees of partnerships in which each partner holds a religious exemption from social security coverage. Second, it would be available to workers in churches and church-controlled nonprofit organizations who are treated as self-employed because the employing church or organization had exercised its option not to pay the employer portion of the social security tax.

Effective date

The change in the exemption pertaining to partnership arrangements would be effective as if included in the Technical and Miscellaneous Revenue Act of 1988. The change in the exemption pertaining to employees of church organizations would be effective for tax years beginning on or after January 1, 1990.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House provision.

5. Prohibition Against Termination of Coverage of U.S. Citizens and Residents Employed Abroad by a Foreign Affiliate of an American Employer

Section 10053 of the House bill.

Present law

U.S. citizens and residents employed abroad by a foreign affiliate of an American employer are covered by social security at the option of the employer through an agreement between the employer and the Secretary of the Treasury. The employer can terminate this coverage by giving 2 years advance notice after the agreement has been in effect for at least 8 years.

House bill

American employers' option to terminate social security coverage of workers in their foreign affiliates would be eliminated.

Effective date

Applies with respect to any coverage agreement in effect on or after June 15, 1989, for which there is no notice of termination in effect on this date.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House provision.

6. Work Incentives for Certain Adult Disabled Children

Sections 10061-10064 of the House bill.

Present law

a. Benefits for those attempting to work.—Disabled social security beneficiaries who attempt to work are provided with a trial work period of up to 9 months, during which earnings cause no reduction in their benefits. By regulation, months which count toward completion of this trial work period are those in which a beneficiary earns \$75 or more. If the Secretary determines that a beneficiary is engaging in Substantial Gainful Activity (SGA) in the month fol-

lowing completion of the trial work period, benefits are suspended two months later. (SGA is currently defined by regulation as earnings of \$300 per month. However, the Secretary published a Notice of Proposed Rulemaking in July 1989 announcing that it would be raising SGA to \$500 per month, effective in January 1990. In addition, the \$75 trigger point for a month of trial work would be raised to \$200.)

At the end of the trial work period, individuals who continue to have a disabling impairment enter a 36-month Extended Period of Eligibility (EPE). During this period, benefits are suspended, except that they can be reinstated without the need for a new application and disability determination for any month in which earnings drop below SGA. Medicare coverage continues for a minimum of 39 months, or a minimum of 3 months past the end of the EPE.

b. Extended period for reapplication for Medicare.—In general, disabled beneficiaries who have completed an extended period of entitlement and continue to work are technically no longer entitled to social security benefits—their entitlement has ceased. However, if they have a disabling impairment during the following 5-year period (i.e., after their entitlement ceases) and their earnings fall below SGA, they can reapply for benefits and return to the disability rolls without being subject to the 5-month waiting period for cash benefits and the 24-month waiting period for medicare benefits that are otherwise required for all newly disabled beneficiaries. Former disabled beneficiaries can reapply after this period but are again subject to a 5-month waiting period for cash benefits and, unless the impairment for the new period of disability is the same as (or directly related to) the impairment in the previous period, to a new 24-month medicare waiting period.

DACs are subject to different reapplication requirements. They can reapply without waiting periods for cash benefits (DACs are never subject to a waiting period for such benefits) and medicare benefits during a 7-year period following cessation of their entitlement. However, after this period, they can apply for DI benefits only on the basis of their own work records (i.e., they cannot reestablish their eligibility as DACs).

House bill

a. New partial benefits system for those attempting to work.—For Disabled Adult Child (DAC) beneficiaries the trial work period and EPE would be replaced with a system that gradually reduces benefits as earnings increase. Under this system, \$85 per month in earnings plus impairment-related work expenses would be disregarded in determining monthly benefits. For earnings in excess of these disregarded amounts, benefits would be reduced \$1 for each additional \$2 earned. For DACs who also are entitled to DI benefits based on their own work record, the entire amount of benefits they receive (i.e., both the DAC and DI portions) would be subject to this system of partial benefit payments. This system would continue so long as the DAC's disabling impairment continues. Medicare coverage would continue for a minimum of 48 months past the first month in which the individual engages in SGA.

The provision would not apply to DACs who (1) are disabled by reason of blindness or (2) those entitled to benefits in June 1990

who have attempted to work but whose earnings have not reached SGA.

b. Extended period for reapplication for Medicare.—During the 5-year period following termination of medicare benefits, DACs who have a disabling impairment and whose earnings fall below SGA could reapply for medicare without being subject to a new 24-month waiting period and would continue to receive medicare so long as their earnings remain below SGA. (During this period they potentially could move in and out of medicare coverage status.) After this 5-year period, they also could reapply for medicare if their earnings fell below SGA and they became or remained impaired. If their impairment were the same as (or directly related to) the original impairment, a new 24-month waiting period would not have to be met; otherwise, it would. Months counting toward completion of this new waiting period would be those in which the individual received a DI benefit.

The provision would not apply to DACs who (1) are disabled by reason of blindness or (2) those entitled to benefits in June 1990 who have attempted to work but whose earnings have not reached SGA.

Effective date

Generally, applies to benefits for months after June 1990. For DAC beneficiaries engaged in trial work for 2 consecutive months as of June 1990, the provision would take effect beginning with the month following such period of consecutive months of trial work.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House provision.

7. Continuation of Disability Benefits During Appeal

Section 10071 of the House bill.

Present law

A DI beneficiary who is determined to be no longer disabled may appeal the determination sequentially through three appellate levels within SSA: (1) a reconsideration, usually conducted by the State disability determination service that rendered the initial unfavorable determination; (2) a hearing before a SSA administrative law judge (ALJ); and (3) a review by a member of SSA's Appeals Council.

The beneficiary has the option of having his or her benefits continued on an interim basis through the hearing stage of appeal. If the earlier unfavorable determinations are upheld by the ALJ, the benefits are subject to recovery by the agency. (If an appeal is made in good faith, recovery may be waived.) Medicare eligibility is also continued, but medicare benefits are not subject to recovery.

P.L. 98-460 provided interim benefits through the hearing stage on a temporary basis. This provision was subsequently extended, most recently by the Technical and Miscellaneous Revenue Act of

1988 (which applies to appeals of termination decisions made on or before December 31, 1989). Under this latest extension, payments may continue through June 30, 1990 (i.e., through the July 1990 check).

House bill

The current provision permitting the payment of benefits upon appeal through the hearing stage would be made permanent.

Effective date

Applies to unfavorable decisions made on or after January 1, 1990.

Senate amendment

No provision.

Conference agreement

The conference agreement provides a one-year extension of the provision.

8. *Elimination of Carryover Reduction in Retirement and Disability Benefits Due to Receipt of Widow's or Widower's Benefits Before Attaining Age 62*

Section 10072 of the House bill.

Present law

If a widow(er) receives actuarially reduced benefits before age 62 and then applies for retirement or disability benefits, the new benefit is subject to a "carryover" reduction. This reduction reflects the fact that social security benefits were already being paid at a reduced rate before the beneficiary filed for retirement or disability benefits. The widow(er) receives the retirement or disability benefit reduced by the carryover reduction, plus any additional widow(er)'s benefit necessary to bring the total benefit amount up to the level of the widow(er)'s benefit if it is larger than the retirement or disability benefit. Since the widow(er)'s benefit in most cases is larger than the retirement or disability benefit, the carryover reduction usually has no effect on the total benefit received.

House bill

The widow(er)'s carryover reduction would be eliminated, i.e., the retirement or disability benefit received by a widow(er) would not be subject to a carryover reduction.

Effective date

Applies to retirement benefits of individuals who attain age 62 on or after January 1, 1990. Applies to disability benefits of individuals who both attain age 62 and become disabled on or after January 1, 1990.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House provision.

9. Modification of Preeffectuation Review Requirement Applicable to Disability Insurance Cases

Section 10073 of the House bill.

Present law

The Social Security Amendments of 1980 require the Secretary of HHS to review 65 percent of favorable disability determinations made by State Disability Determination Services (DDSs) before the decision becomes effective. The review applies to favorable decisions on initial claims, reconsiderations, and continuing disability investigations.

House bill

The Secretary would be required to review 50 percent of DDS allowances and 25 percent of continuances. The 50 percent requirement would apply both to initial claims and reconsiderations. To the extent feasible, the reviews would focus on allowances and continuances that are likely to be incorrect.

Effective date

Applies to DDS determinations made in FY 1990 and thereafter.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House provision.

10. Recovery of OASDI Overpayments by Means of Reduction in Tax Refunds

Section 10074 of the House bill.

Present law

A federal agency that is owed a past-due, legally enforceable debt, other than a social security overpayment, can collect it by having the Internal Revenue Service (IRS) withhold or reduce the debtor's income tax refund. To recover a debt through the tax system, the agency to which it is owed must:

(a) notify the individual of its intention to recover the debt through the tax system;

(b) provide the individual with at least 60 days to present evidence that all or part of the debt is not past-due or not legally enforceable; and

(c) consider any evidence presented by the individual and make a final determination that the debt is in fact owed and legally enforceable.

After the agency notifies IRS of its final determination, IRS reduces the amount of the individual's income tax refund (if any); pays this amount to the agency; and notifies the individual of the

amount by which the tax refund has been reduced to repay the debt.

House bill

SSA would be permitted to recover social security overpayments from former beneficiaries (individuals not currently receiving benefits) through arrangements with the IRS to offset the individual's tax refund. Notice of the recovery action would be given to all parties involved in a joint return of how to protect the refund of any individual not involved in the overpayment. The amounts recovered in this manner would be credited to the appropriate social security trust fund.

Effective date

The provision would take effect January 1, 1990 and would remain in effect as long as the existing, government-wide offset remains in effect (currently, until January 10, 1994).

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House provision.

11. Exemption of Certain Aliens Receiving Amnesty Under the Immigration Reform and Control Act From Liability for Misreporting of Earnings or Misuse of Social Security Account Numbers or Social Security Cards

Section 10075 of the House bill.

Present law

The use of a false social security number or card or the misreporting of earnings covered by social security, with intent to deceive, is a felony under section 208 of the Social Security Act, punishable by a maximum cash penalty of up to \$250,000, and up to 5 years imprisonment. The Immigration Reform and Control Act of 1986 (IRCA) extended amnesty and the opportunity to obtain legal status to certain aliens who had been resident and working in the U.S. for a substantial period of time. However, persons legalized under IRCA are still subject to prosecution for use of a false social security number or card under section 208.

House bill

Aliens who applied for and were granted legal status under IRCA and section 902 of the Foreign Relations Authorizations Act for Fiscal Years 1989 and 1990 would not be prosecuted for certain violations of section 208 of the Social Security Act. These violations are: (1) having used a false social security number or card with intent to deceive; and (2) having misreported earnings with intent to deceive.

The provision would not apply to those individuals whose violations consisted of: (1) selling a card that is or purports to be a social security card issued by the Secretary; (2) possessing a social securi-

ty card with intent to sell it; and (3) counterfeiting a social security card with intent to sell it.

Effective date

Applies to cases of misuse alleged to have occurred prior to 30 days after enactment.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House provision.

12. Adjustments in the Retirement Test Exempt Amount for Those Age 65-69

Section 10076 of the House bill.

Present law

In 1989, social security beneficiaries age 65-69 who earn more than \$8,880 in annual wages or self-employment income incur a reduction in their benefits. Beneficiaries under age 65 incur a reduction when their earnings exceed \$6,480. For each \$2 of earnings in excess of these amounts, social security benefits are reduced by \$1. These exempt amounts are automatically adjusted each year to reflect the change in the average wage in the economy. Beneficiaries age 70 and older can earn any amount without incurring a reduction in benefits.

Beginning in 1990, the reduction for workers age 65-69 will change from a \$1 loss in benefits for each \$2 of earnings over the exempt amount to a \$1 loss in benefits for each \$3 of earnings (no change in the reduction rate will occur for those under age 65).

The exempt amount for those age 65-69 will be \$9,360 in 1990 and is projected to be \$9,840 in 1991.

House bill

The exempt amount for beneficiaries age 65-69 would be raised \$360 in 1990 and an additional \$240 in 1991 above the levels that would occur under the automatic procedure. Together, the two increases would result in a \$600 ad hoc adjustment to the exempt amounts. The resulting exempt amounts would be \$9,720 in 1990 and a projected \$10,440 in 1991. Automatic increases of the exempt amounts in future years would be calculated based on inclusion of these ad hoc increases.

CBO would be required to study: (a) the distribution of benefit increases by various earnings categories resulting from the elimination of, or alternative increases in, the retirement test, (b) the impact on the OASI trust fund of such alternatives, and (c) the impact on labor force participation of such alternatives.

Effective date

Applies to taxable years ending after 1989. The study would be due April 1, 1990.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House provision.

13. Increase in the Special Minimum Benefit

Section 10077 of the House bill.

Present law

A "special minimum" social security benefit is available to workers who have many years of work at modest wages. The amount of this benefit is determined by an alternative benefit computation procedure that calculates the benefit based on the number of years of significant earnings, rather than on average lifetime earnings. It applies in cases where this computation procedure results in a higher benefit than that which would be derived under the regular social security benefit computation rules.

The special minimum benefit is computed by multiplying the number of years of special minimum coverage by a base amount. However, only those years in excess of 10 and up to 30 can be multiplied by the base amount (e.g., if an individual has 30 years of coverage toward the special minimum, only 20 of these years can be multiplied by the base amount to determine the benefit amount). In 1989, the base amount is \$20.90. In 1990, it be \$21.88. (A new base amount is not actually promulgated by the Secretary each year; rather, the base amounts used in this description are derived from the table of special minimum benefit amounts published by the Secretary each year. This table was established using the 1979 base amount, \$11.50, and the benefit amounts are updated each year by the social security cost-of-living adjustment.) In 1990, a worker with 30 years of coverage would be eligible for \$437.60 per month.

For the period 1937-1950, an individual's years of coverage toward the special minimum are determined by dividing the total amount of wages or self-employment income credited in that period by \$900, although the number of years of coverage awarded cannot exceed 14. For later years, an individual qualifies for a year of coverage for each year in which earnings meet or exceed a minimum amount specified in law. For the years 1951-1978, the minimum amount is 25 percent of the taxable earnings base for that year. For years after 1978, the minimum amount is 25 percent of the "old-law" taxable earnings base for that year (i.e., the hypothetical earnings base that would be in effect if the ad hoc increases in the base enacted in 1977 were disregarded). In 1989, the amount of earnings required for a year of coverage toward the special minimum is \$8,925. In 1990, it will be \$9,375.

House bill

The special minimum benefit base amount would be increased, and the minimum amount of earnings needed to qualify for a year of coverage toward the special minimum would be reduced.

The special minimum base amount would be increased in 1990 by \$1.70—raising it from \$21.88 to \$23.58. Thus, in 1990, the benefit for a worker with 30 years of coverage would be \$471.60 per month. As under current law, the special minimum benefit amounts as increased by this provision would be subject to future increases based on cost-of-living adjustments.

The amount of earnings needed to qualify for a year of coverage toward the special minimum would be reduced from 25 percent to 15 percent of the “old law” taxable earnings base. In 1990, the minimum amount of earnings would be \$5,625, rather than \$9,375 under present law.

Medicaid eligibility would be continued for those individuals who might otherwise lose it as a result of the higher special minimum benefit.

Effective date

The higher benefit amounts would become effective with respect to benefits for months after December, 1989. The reduction in the amount of earnings needed to qualify for a year of coverage under the special minimum would become effective for years of coverage earned after 1989.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House provision.

14. Elimination of Eligibility for Retroactive Benefits for Certain Individuals Eligible for Reduced Benefits

Section 10078 of the House bill.

Social security retirement and survivor benefits can be paid for up to 6 months prior to the month of application if the applicant were otherwise eligible for benefits during that period. Benefits based on disability can be paid for up to 12 months prior to the month of application.

However, retroactive benefits generally cannot be paid if doing so would cause a reduction in future monthly benefits (i.e., it would effectively mean that an individual would be filing for “early retirement,” in which case an actuarial reduction in benefits is required). For example, if a retroactive application for retirement benefits were to cause a retiree’s initial entitlement month to fall before the individual reached age 65, no retroactive benefits can be paid for the months prior to age 65. There are four exceptions to this rule which permit payment of retroactive benefits even though it causes an actuarial reduction in benefits:

(a) if an individual has dependents who would be entitled to unreduced benefits during the retroactive period;

(b) if an individual has excess earnings under the social security retirement test (i.e., earnings above the exempt amounts) that could be charged off against benefits for months prior to the month of application;

(c) if an individual is applying for widow(er)'s or surviving divorced spouse's benefits on the basis of disability for months prior to reaching age 60 (this exception is now inoperative because benefits are no longer further reduced for entitlements commencing prior to age 60); or

(d) if a widow(er) is applying for survivor benefits for the preceding month and the death of his or her spouse occurred in that month.

House bill

Eligibility for retroactive benefits would be eliminated for 2 categories of individuals eligible for actuarially reduced benefits:

(a) individuals who have dependents who would be entitled to unreduced benefits during the retroactive period; and

(b) individuals who have excess earnings under the social security retirement test (i.e., earnings above the exempt amounts) that could be charged off against benefits for months prior to the month of application.

Effective date

Applies with respect to applications for benefits filed on or after January 1, 1990.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House provision.

15. Treatment of Employer-Paid Life Insurance Premiums Under the Railroad Retirement Tax Act

Section 10081 of the House bill.

Present law

Some forms of employee compensation are treated differently under the Railroad Retirement Tax Act (RRTA), which applies to the railroad retirement program, and the Federal Insurance Contributions Act (FICA), which applies to social security. Under FICA, employer-paid premiums for life insurance are generally not considered wages, and therefore are not subject to the social security payroll tax. An exception is made for the value of employer-paid premiums for group-term life insurance coverage in excess of \$50,000, which is included in the definition of wages and thus is subject to social security payroll taxes.

RRTA does not refer to life insurance. However, IRS regulations relating to RRTA exclude employer-paid life insurance premiums from the definition of taxable employee compensation.

House bill

The value of employer-paid premiums for group-term life insurance coverage in excess of \$50,000 would be included in the definition of compensation under RRTA and would therefore be subject to railroad retirement payroll taxes. Also, the provision would

amend the RRTA to exclude generally the value of employer-paid life insurance premiums from the definition of compensation. These changes would bring into conformity the treatment of life insurance premiums under the social security and railroad retirement programs.

Effective date

The provision would be effective with respect to coverage in effect after December 31, 1989, except in the case of former employees who separated from employment on or before December 31, 1989. Due to confusion about the taxable status of this remuneration, some employers may have withheld and paid payroll taxes on remuneration paid before January 1, 1990. Because these amounts would already have been credited for benefit purposes, and because it is likely that some employees would already have begun receiving benefits based on the crediting of such amounts, no refund of taxes paid on remuneration paid before January 1, 1990, would be made.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House provision.

16. Treatment of Certain Deferred Compensation and Salary Reduction Arrangements Under the Railroad Retirement Tax Act

Section 10082 of the House bill.

Present law

Under the Federal Insurance Contributions Act (FICA), employer-sponsored tax-qualified pension plans are generally excluded from the definition of wages and therefore are not subject to the social security payroll tax. There are two exceptions, both relating to deferred compensation, to this general exclusion.

The first exception is for qualified cash or deferred arrangements (described in section 401(k) of the Internal Revenue Code). Under a cash or deferred arrangement forming a part of a qualified profit-sharing or stock bonus plan, a covered employee may elect either to have the employer contribute an amount to the plan on the employee's behalf or to receive such amount directly in cash. Amounts contributed to the plan are treated as employer contributions, are includible in wages, and are subject to the FICA tax.

The second exception is for deferred compensation plans other than those specifically provided for in the general exclusion for tax-qualified pension plans. They are referred to as "nonqualified deferred compensation plans." Amounts contributed to these types of plans are includible as wages and are taxable under FICA.

The Railroad Retirement Tax Act (RRTA) does not refer either to pensions or to deferred compensation arrangements in its definition of compensation subject to payroll taxation.

House bill

The RRTA would be amended to bring the treatment of deferred compensation arrangements, and pensions generally, into conformity with their treatment under FICA. Thus, employer-sponsored tax-qualified plans generally would be specifically excluded from the definition of compensation under RRTA and would therefore not be subject to railroad retirement payroll taxes. However, contributions to qualified 401(k) cash or deferred arrangements and contributions to nonqualified deferred compensation plans would both be included in compensation (and would therefore be subject to railroad retirement payroll taxes) to the same extent they are now included in wages for FICA tax purposes.

Effective date

With respect to pensions generally, the provision would be effective for remuneration paid after December 31, 1989. With respect to deferred compensation arrangements, the provision would be effective for remuneration paid after December 31, 1989, (including remuneration paid after December 31, 1989, which is for services performed before January 1, 1990) with the following two exceptions: (1) with respect to qualified 401(k) cash deferred arrangements, a transition rule is provided to exclude certain remuneration paid after December 31, 1989, if paid pursuant to certain elective deferrals made before January 1, 1990; and (2) in the case of certain agreements in existence on June 15, 1989, between a non-qualified deferred compensation plan and an individual, the provision would only apply to services performed after December 31, 1989. Due to confusion about the taxable status of this remuneration, some employers may have withheld and paid payroll taxes on remuneration paid before January 1, 1990. Because these amounts would already have been credited for benefit purposes, and because it is likely that some employees would already have begun receiving benefits based on the crediting of such amounts, no refund of taxes paid on remuneration paid before January 1, 1990, would be made.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House provision.

17. Codification of Rowan with Respect to Railroad Retirement

Section 10083 of the House bill.

Present law

In a 1981 case, *Rowan Companies, Inc. v. United States*, the Supreme Court ruled that the definition of "wages" for Federal Insurance Contributions Act (FICA) purposes must be interpreted in regulations in the same manner as for income-tax withholding purposes. At issue in the case was the treatment of meals and lodging provided for the convenience of the employer. The Social Security Act Amendments of 1983 codified Rowan with respect to meals and

lodging, but in all other cases stated that nothing in the regulations prescribed for the purposes of income tax withholding which provides an exclusion from "wages" shall be construed to require a similar exclusion from "wages" in the regulations prescribed for the purposes of FICA. Similar language was not included in the Railroad Retirement Tax Act (RTA).

House bill

The provision would amend the RTA to state that, except in the case of meals and lodging provided for the convenience of the employer and excludible for purposes of income tax withholding, nothing in the regulations prescribed for purposes of income tax withholding which provides an exclusion from "wages" shall be construed to require a similar exclusion from "compensation" in the regulations prescribed for purposes of the RTA.

Effective date

The provision would be effective for remuneration paid after 1989.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House provision.

18. General Fund Transfers to Railroad Retirement Tier II Trust Fund

Section 10084 of the House bill.

Present law

Proceeds from the income taxation of railroad retirement Tier II benefits received prior to October 1, 1989 are transferred from the general fund of the U.S. Treasury into the Railroad Retirement Account. Proceeds from the taxation of benefits received after this date will remain in the general fund.

House bill

The provision would extend the transfer of proceeds from the taxation of railroad retirement Tier II benefits from the general fund into the Railroad Retirement Account for one year, to apply to benefits received prior to October 1, 1990.

Effective date

October 1, 1989.

Senate amendment

No provision.

Conference agreement

The conference includes the House provision.

19. Inclusion of Certain Deferred Compensation in Calculation of Average Wages

Section 10079 of the House bill.

Present law

The social security taxable earnings base, the benefit formula, and certain other social security program amounts are increased each year in accordance with the increase in the average of total wages reported to the Secretary of HHS (through a delegation from the Secretary of the Treasury) including wages that are not taxable for social security purposes (e.g., noncovered earnings and earnings above the taxable earnings base). By regulation, the Secretary of HHS has defined total wages for this calculation to be those that are reported for income tax purposes. Since various forms of deferred compensation are not subject to income tax at the time of the deferral (e.g., elective deferrals under a qualified cash or deferred arrangement as defined in section 401(k) of the Internal Revenue Code), they are not included in the calculation of average wages for Social Security purposes.

House bill

For purposes of measuring the annual increase in average wages, such wages would include certain deferred compensation, including 401(k) plans. A transition provision would provide that the inclusion of deferred compensation in average wages would be phased-in so that it would be included first for taxable earnings base purposes and subsequently for benefit and other program amount purposes.

Effective date

For purposes of determining the taxable earnings base, an estimate of deferred compensation would be included in average wages for 1988 and 1989, so that the 1990 taxable earnings base would reflect the inclusion of deferred compensation in average total wages. Actual deferred compensation amounts would be used beginning with 1990 wages.

For purposes of benefit computations and other program amounts, actual deferred compensation amounts would be included beginning with 1990 wages and would be reflected in benefit computations and other program amounts beginning in 1993.

Senate amendment

No provision.

Conference agreement

The conference includes the House provision.

20. Treatment of Refunds by Employers under the Medicare Catastrophic Coverage Act of 1988 for FICA and Social Security Benefit Purposes and for Other Purposes

Section 10054 of the House bill.

Present law

The Medicare Catastrophic Coverage Act of 1988 includes a maintenance-of-effort provision which requires that employers who offer health insurance benefits which overlap the new medicare benefits must provide either additional benefits or a refund to individuals covered by the employer's plan during the first two years the Act is in effect.

House bill

Refunds to individuals by employers under the maintenance-of-effort provision of the Medicare Catastrophic Coverage Act of 1988 would be excluded from wages for FICA and FUTA tax purposes and from compensation for railroad retirement and railroad unemployment insurance tax purposes. Thus, these amounts would not be taken into account in calculating average wages for purposes of determining the social security contribution and benefit base, the railroad retirement contribution and benefit base, and other social security and railroad retirement amounts, and for purposes of the federal-state unemployment insurance system and the railroad unemployment insurance program.

Effective date

The provision would be effective for the 2 years that employers are required to make the refund payments, 1989 and 1990.

Senate amendment

No provision.

Conference agreement

The conference includes the House provision. It also includes an additional provision giving the Secretary of the Treasury authority to prescribe the manner in which these refunds would be reported.

*21. Extension of Disability Insurance Program Demonstration
Project Authority*

Present law

Section 505(a) of the Social Security Disability Amendments of 1980 (P.L. 96-265), as extended by the Consolidated Omnibus Reconciliation Act of 1985 (P.L. 99-272), authorizes the Secretary to waive compliance with the benefit requirements of titles II and XVIII for the purpose of conducting work incentive demonstration projects to encourage beneficiaries to return to work. This authority will expire June 10, 1990.

House bill

No provision.

Senate amendment

No provision.

Conference agreement

The work incentive demonstration project authority would be extended for three years, through June 10, 1993.

*22. Earnings and Benefit Statements**Present law*

There is no statutory requirement that the Social Security Administration provide individuals with earnings and benefit statements. Upon request, SSA currently will provide an individual with such information.

House bill

No provision.

Senate amendment

No provision.

Conference agreement

Beginning not later than October 1, 1990, the Secretary would be required to provide individuals, aged 25 and older, who have a social security number and have wages or net self-employment income, with a social security account statement upon the request of the individual. These statements would show (1) the individual's earnings, (2) an estimate of the individual's contributions to the social security program (including a separate estimate for HI), and (3) an estimate of the individual's future benefits at retirement (including those of auxiliaries) and a description of medicare benefits. Starting in 1995, these statements would be automatically provided to all such individuals who attain age 60 (but are not yet receiving benefits) during that year and for whom the Secretary can determine a current address. Each statement sent to an eligible individual would include a notice stating that these statements are updated annually and are available upon request. Starting in 1999, these statements would be automatically provided on a biennial basis to those under age 60 as well (benefit estimates would not be required in the case of persons under age 50, although a general description of benefits would be required).

Effective date

As previously described, the provision would be phased in gradually between October 1, 1990 and October 1, 1999.

PROVISIONS AFFECTING SOCIAL SECURITY AND SSI RECIPIENTS

1. Improvements in Social Security Services

Sections 10021-10030 of the House bill.

Present law

a. Standards governing collection of overpayments.—When a beneficiary is paid more than the correct amount of social security benefits, the Secretary must attempt to recover the overpayment by:

- (i) requiring the individual or his or her estate to refund the amount;
- (ii) decreasing any payment to which the individual is entitled;
- (iii) decreasing any payment to his or her dependents or estate; or
- (iv) using any combination of these measures. Repayment is waived if the individual is without fault in causing the overpayment and recovery would defeat the purposes of the program or would be against "equity and good conscience."

b. Demonstration projects relating to accountability for telephone service center communications.—The Social Security Act is silent regarding telephone service provided by SSA. In practice, SSA currently operates 37 teleservice centers (TSCs) that respond to inquiries from the public. In addition to providing general program information, these TSCs can schedule appointments at local offices and provide individual service, including discussing an individual's eligibility and taking specific actions regarding the individual's benefits. In recent years SSA has attempted to increase the amount of services and actions handled over the telephone by implementing a toll-free 800-number and reallocating staff resources to telephone service workstations, and by promoting its telephone service abilities with the public.

After the 800-number becomes fully operational local office numbers will no longer be listed in phone books and calls to these numbers will be diverted to it, thereby curtailing or eliminating telephone channels that the public has with local offices.

c. Standards applicable in certain determinations of good cause, fault, and good faith.—

Good cause—A Social Security beneficiary who (i) works for more than 45 hours during a month in noncovered employment outside the U.S., (ii) ceases to have a child in care, or (iii) has earnings in excess of the annual exempt amount under the retirement test, is subject to a penalty for failure to report these facts to SSA. However, if the individual can demonstrate to the satisfaction of the Secretary that he or she had good cause for failing to make a timely report, the penalty is waived. In addition, disability benefits are terminated when a beneficiary fails, without good cause, to cooperate with the Secretary in reviewing his or her entitlement or in following a treatment which is expected to restore his or her ability to work.

Fault—Overpayments to beneficiaries are waived in cases where the individual is without fault and recovery would defeat the purposes of the program or would be against "equity and good conscience." SSA regulations state that in determining whether an individual is without fault, consideration will be given to the individual's age, intelligence, education, and physical and mental capabilities.

Good faith—A beneficiary receiving benefits based on disability whom the Secretary determines is no longer disabled has the option of having his or her benefits continued through a hearing before an Administrative Law Judge (ALJ). Benefits paid during this period are considered overpayments if the

beneficiary loses the appeal. However, if the beneficiary acted in good faith in pursuing the appeal, repayment can be waived. SSA regulations establish a presumption that appeals are made in good faith unless the beneficiary fails to cooperate with the agency during the appeal.

d. Assistance to the homeless.—SSA has participated in projects designed to assist the homeless in qualifying for social security or SSI benefits. No provision exists expressly delineating SSA responsibilities with regard to enrolling potentially eligible homeless people.

e. Notice requirements.—The Secretary must use understandable language in notifying individuals of a denial of disability benefits. The law is silent regarding the language of other notices.

Blind SSI applicants and recipients may opt to be informed by telephone of a decision or action affecting them within 5 days of the mailing of written notices of such action, to have such notices sent by certified mail, or to receive them through some other means established by the Secretary. These options are not available to blind social security applicants and recipients.

f. Representation of claimants.—Social security claimants and beneficiaries may use attorneys and legal assistance representatives in pursuit of their claims and in taking other action before the agency. The Secretary is not required to advise claimants or beneficiaries of options regarding their possible use of attorneys and legal aid representatives. When a claimant or a beneficiary decides to use one, SSA requires the individual to formally designate the representative. SSA is under no legal requirement to maintain an automated list of attorneys and legal aid representatives who have this written authorization to assist claimants and beneficiaries with their cases before the agency.

g. Applicability of administrative res judicata; related notice requirements.—If a claimant for social security or SSI disability benefits successfully appeals an adverse determination by the Secretary, benefits can be paid retroactively for up to 12 months prior to the date of the original application.

If, however, instead of appealing, the claimant reapplies and is subsequently found to be disabled as of the date originally alleged, there are circumstances where retroactive benefits would be limited to 12 months from the date of the subsequent application (rather than the date of the first). This occurs when SSA determines that it cannot reopen the original decision under its "reopening rules." (SSA's administrative policy permits a case to be reopened within 12 months of an initial determination for any reason; and within 4 years (2 years for SSI claims) if there is new and material evidence or the original evidence clearly shows on its face that an error was made in the original decision).

A reapplication, in lieu of an appeal, also could result in an outright denial of social security benefits without even considering an individual's medical evidence. This occurs when (i) the claimant's insured status ran out before the date of the original denial or the recency-of-work test cannot be satisfied since then, and (ii) there is no new and material evidence and no facts or issues that were not considered in making the prior decision. In this situation, SSA applies the legal principle of *res judicata* to deny the subsequent

claim. Under this principle—the use of which is prescribed by SSA regulations—SSA will not consider the same claim over and over again.

Prior to May 1989, SSA's standard denial notice informed claimants that they could reapply at any time, but did not explain the potential adverse consequences of reapplying versus appealing a denial. A May 1989 modification of this notice informs claimants that reapplying may result in a loss of benefits, but does not mention the second problem described above, i.e., an outright denial of eligibility.

h. Authority for Secretary to take into account misinformation provided to an applicant in determining date of application.—By regulation, if an individual expresses his intention to file for Social Security or SSI benefits in a telephone call to SSA, the SSA representative is required to establish a protective application at the time of the call. These procedures enable an applicant to establish the date of the call as the filing date if the applicant subsequently qualifies for benefits. If the individual does not express his or her intention to file for benefits, a protective filing date is not assigned, even if failure to express such interest is caused by misinformation communicated in the call by the SSA representative.

i. Same-day personal interviews at SSA field offices in cases where time is of the essence.—Nothing in current law requires SSA offices to respond promptly to individuals who visit them on matters of personal urgency or under time deadlines imposed by the agency.

j. Authority to amend wage records after expiration of time limitation.—The Secretary is required to establish and maintain records of workers' wages and self-employment income. Errors in these records can be corrected at any time up to 3 years, 3 months, and 15 days after the year in which the earnings occurred. After this time, various revisions can be made including ones in which an employer neglected to report covered wages. However, no revision is permitted where an employer misreported the amount of the earnings.

House bill

a. Standards governing collection of overpayments.—Except in cases involving fraud, concealment, or willful misrepresentation, the Secretary would be required to recover any overpayment subject to recovery on a schedule that would not cause the beneficiary undue financial hardship. In cases where the beneficiary is also receiving SSI, the overpayment would be recovered by withholding 10 percent of the beneficiary's monthly social security check.

Effective date

Applies to adjustments made, and recoveries obtained, on or after January 1, 1990.

Senate provision

No provision.

Conference agreement

The conference agreement does not include the House provision.

b. Demonstration projects relating to accountability for telephone service center communications.—The Secretary would be required to carry out demonstration projects testing a set of accountability procedures in at least 3 teleservice centers. Callers who provide adequate identifying information would be provided with written confirmation of the date and nature of their calls, including the name of the employee to whom they spoke, a description of any action the employee said would be taken, and any advice the caller was given. Routine communications (that is, calls that do not relate to potential or current eligibility for benefits) would be excluded.

The Secretary would be required to make periodic reports to the House Ways and Means and the Senate Finance Committees on the progress of these demonstrations, including costs and benefits, difficulties encountered, and an assessment of the feasibility of implementing the procedures nationally.

Effective date

These projects must begin within 6 months after enactment and continue for 1 to 3 years. Periodic reports are due 9 months after the projects' inception and final reports are due 90 days after termination. (Additional annual reports would be required if the demonstration projects extend more than one year).

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House provision.

c. Standards applicable in certain determinations of good cause, fault, and good faith.—In making determinations of whether a title II beneficiary:

- (i) is without fault in an overpayment,
- (ii) has acted in good faith in appealing a termination of his disability benefits,
- (iii) has good cause for having failed to make a timely report of overseas work, of earnings above the retirement test exempt amount, or of ceasing to have a child in care, or
- (iv) has good cause for having failed to participate in a reassessment of his disability or in a program of treatment, the Secretary would be required to take into account any physical, mental, educational, or linguistic limitations that the individual has (including any lack of facility in the use of English).

Similar provisions apply with respect to SSI.

Effective date

Applies to determinations made on or after January 1, 1990.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House provision, except that it applies to determinations made on or after July 1, 1990.

d. Assistance to the homeless.—The Secretary would be required to establish a program to identify homeless individuals who may be eligible for social security or SSI benefits and to provide reasonable assistance to them in making application. In addition, the Secretary would be required to cooperate in joint projects to facilitate benefit applications on behalf of the homeless when requested by State or local government or nonprofit organizations, including making regular visits to facilities aiding the homeless. Annual report to the House Ways and Means and the Senate Finance Committees on this outreach effort would be required.

Effective date

The program of assistance to the homeless would be established no later than 180 days after enactment.

Senate provision

No provision.

Conference agreement

The conference agreement does not include the House provision.

e. Notice requirements.—With regard to notices about social security and SSI benefits, the Secretary would be required to use clear and simple language. Notices generated by local offices would include the name, address, and telephone number of a responsible contact person. Other notices would include the name and address of the individual's local servicing office and the telephone number through which that office can be reached.

In addition, the Secretary would be required to submit a report to the House Ways and Means and the Senate Finance Committees on current procedures for providing social security and SSI notices in foreign languages and options for making greater use of them with individuals having limited English-speaking capacity.

With regard to the blind, the notification options currently available to SSI applicants and recipients would be extended to social security applicants and recipients.

Effective date

Applies to notices issued on or after January 1, 1990.

The required report on foreign language notices would be due July 1, 1990.

Senate provision

No provision.

Conference agreement

The Conference agreement includes the House provisions dealing with foreign language notices and notices to the blind but does not include the House provision dealing with general SSA notices. The report dealing with foreign language notices would be due January 1, 1991. The provision dealing with notices for the blind would be effective for notices issued on or after July 1, 1990.

f. Representation of claimants.—The Secretary would be required to maintain an up-to-date electronic record, accessible to SSA offices through the agency's computer system, of the identities of

legal representatives of all social security claimants. In addition, the Secretary would be required to include in benefit denial notices information on options for obtaining legal representation before the agency. Such notices also would include information about the availability of legal service organizations that provide assistance free-of-charge to qualified claimants.

Effective date

The provision requiring an electronically retrievable list of legal representatives would be effective July 1, 1990; the provision requiring denial notices to contain options for legal representation would be effective on or after January 1, 1990.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House provision. The provision requiring an electronically retrievable list of legal representatives would be effective June 1, 1991; the provision requiring denial notices to contain a description of options for legal representation would be effective on or after January 1, 1991.

g. Applicability of administrative res judicata; related notice requirements.—When a claimant for social security or SSI benefits can demonstrate that he or she failed to appeal an adverse decision because of reliance on incorrect, incomplete, or misleading information provided by SSA, his or her failure to appeal could not serve as the basis for denial by the Secretary of a second application for any payment under this title. The Secretary also would be required to include in all notices of denial a clear, simple description of the effect on possible entitlement to benefits of reapplying rather than making an appeal.

Effective date

Applies to adverse determinations made on or after January 1, 1990.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House provision.

h. Authority for Secretary to take into account misinformation provided to an applicant in determining date of application.—When an individual can demonstrate to the Secretary's satisfaction that he or she failed to file for social security or SSI benefits as a result of misinformation concerning eligibility provided by SSA, the individual would be deemed to have applied on the later of (i) the date the incorrect information was provided, or (ii) the date the individual met all the requirements for entitlement.

Effective date

Applies with respect to benefits for months after December 31, 1959.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House provision. With respect to social security, it would be effective for misinformation provided after December 1982 and for benefits for months after December 1982. With respect to SSI, it would be effective for misinformation provided on or after the date of enactment and for benefits for months after the date of enactment.

i. Same-day personal interviews at SSA field offices in cases where time is of the essence.—When an individual visits a field office during normal business hours in response to a time-limited notice for action sent by SSA or because his or her social security or SSI check was lost, stolen, or not received, the Secretary would be required to assure that the individual receives a face-to-face interview with an SSA employee before the close of the business day.

Effective date

Applies to visits to SSA field offices on or after January 1, 1990.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House provision. The conferees intend that nothing in this section should diminish what they regard as SSA's continuing responsibility to provide same-day interviews to other individuals who visit the office.

j. Authority to amend wage records after expiration of time limitation.—The current list of revisions to earnings records that can be made after 3 years, 3 months, and 15 days from the year of the earnings would be expanded to permit adding wages to a record where an entry for an employer is present but incorrect.

Effective date

The provision would be effective upon enactment.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House provision.

2. Representative Payee Reforms

Sections 10031-10033 of the House bill.

Present law

a. Procedures for Selection and Recruitment of Representative Payees.—The Secretary may appoint a person to receive social security or SSI benefits on behalf of a beneficiary if it appears to be in the best interest of the beneficiary, regardless of the beneficiary's

legal competence or incompetence. This representative payee can be a spouse, parent, other relative, or some other person (although the law precludes an individual convicted of a felony under sections 208 or 1632 of the Social Security Act from being a representative payee). The Secretary is required to investigate the representative payee either prior to or within 45 days of certifying payments to him or her. Present law is silent as to the content of the investigation.

SSA Programs Operation Manual System (POMS) lays out criteria for selecting and investigating a representative payee. These include:

- Conducting a face-to-face interview with the representative payee applicant whenever possible,

- Determining the capability of the representative payee applicant to carry out the duties of the payee,

- Assessing the representative payee applicant's awareness of the beneficiary's situation and needs, and

- Determining the representative payee applicant's relationship to the beneficiary and the extent to which he or she has demonstrated concern for the beneficiary's well-being.

Direct payment to recipients. Nothing in title II of the Social Security Act permits or prohibits the withholding benefits until a representative payee is found. Title XVI prohibits direct payment of SSI benefits to those medically determined to be alcoholics or drug addicts.

The Ninth Circuit Court of Appeals in *Briggs v. Sullivan*, (September, 1989) ordered the district court to enter an injunction requiring the Secretary to pay social security benefits or SSI benefits directly to adult beneficiaries in California when a suitable representative payee cannot be found. Two groups are excluded from this order: (1) SSI recipients receiving benefits on the basis of alcohol or drug-related disabilities; and (2) Social security beneficiaries and SSI recipients who have been declared legally incompetent.

Compensation for qualified organizations that serve as representative payees. Present law is silent regarding compensation for the costs incurred by the representative payee in providing representative payee services to social security and/or SSI recipients. SSA regulations permit a representative payee to deduct from the beneficiary's monthly check the actual out-of-pocket expenses of providing payee services, such as stamps, travel, and phone expenses.

In the recent past, SSA also permitted certain organizations providing representative payee services to collect a fee for services from the beneficiary's check. Citing a lack of statutory authority, SSA discontinued this practice.

b. Accounting Procedures.—Title II and title XVI of the Social Security Act, require the Secretary to establish a system of accountability monitoring in cases involving a representative payee whereby the representative payee reports not less often than annually with respect to the use of the payments. This requirement applies to payees who are not (i) the parent or spouse living in the same household with the beneficiary or (ii) a Federal or State institution. Further, the Secretary is required to establish statistically valid procedures for reviewing these reports to identify cases of improper use.

[NOTE: In 1984, a U.S. District Court ruled in *Jordan v. Bowen* that all representative payees must account for expenditures made on behalf of the beneficiary. This ruling, later upheld by an Appeals Court, included those who were parents or spouses of a beneficiary living in the same household. It did not apply to Federal and State institutions which are subject to periodic on-site review. *Jordan* was a nationally certified class action suit. The ruling was based on the constitutional right to due process and therefore supersedes statute.]

In addition, the Secretary may require a report at any time from a representative payee if the Secretary has reason to believe that the representative payee is misusing such payments.

The law provides that a representative payee who knowingly and willfully uses payments to the beneficiary in ways that do not benefit him or her, will be guilty of a felony and subject to fines and imprisonment for up to 5 years (and permits the Court to require full or partial restitution in the event of a subsequent conviction).

House bill

a. Procedures for selection and recruitment of representative payees.—

Representative payee investigations. The Secretary would be required to investigate representative payees in advance of certifying payments to them. In conducting the investigation, SSA would be required to secure adequate evidence that designating a representative payee is in the best interest of the social security or SSI recipient; obtain documented proof of the representative payee's identity; verify his or her social security or employer identification number; determine whether he or she has been convicted of a social security felony under section 208 or 1632 or previously dismissed as a representative payee for misuse of funds. In general, benefit payments would not be certified to an individual who has previously been terminated for misuse of funds; however, in rare instances, the Secretary would be permitted to grant an exception to this prohibition on a case by case basis, if it would be in the interest of the beneficiary.

Feasibility study. As soon as practicable, the Secretary would be required to study, in consultation with the Attorney General and the Secretary of the Treasury, the feasibility of establishing and maintaining a list of the names and social security account numbers of individuals convicted of social security check fraud violations, and providing such a list to all local offices for use in representative payee investigations. A report would be due to the House Ways and Means and the Senate Finance Committees not later than July 1, 1990.

Direct payment to recipients. When the Secretary is unable to find a suitable representative payee, and the Secretary determines that it would be in the best interest of the social security or SSI recipient to withhold direct payment, the Secretary would be permitted to do so for up to two months.

After the two-month period, the Secretary would be required to begin making current monthly payments directly to the ben-

eficiary unless that person had been declared legally incompetent or was under the age of 15.

Retroactive benefits would be paid either to the representative payee or to the beneficiary over such a period as the Secretary determines would be in the best interest of the beneficiary.

Direct payment of benefits to SSI recipients who receive benefits on the basis of alcohol or drug related disability would be prohibited.

Compensation for qualified organizations that serve as representative payees. Community-based nonprofit social service agencies (defined as agencies which are representative of communities or significant segments of communities and regularly provide services to those in need) that serve as payee for more than 5 social security or SSI recipients would be able to draw a fee from the benefits they administer for serving as representative payees (if they were not also creditors of the beneficiaries). The Secretary would define the maximum fee in regulations, which could not exceed the expenses incurred in providing services (including direct costs and overhead). Qualified organizations that charge or collect, or make arrangements to charge or collect, a fee in excess of the maximum fee, would be guilty of a misdemeanor punishable by a fine not exceeding \$500, or imprisonment not exceeding one year, or both.

Demonstrations relating to screening of individuals with criminal records. The Secretary would be required to develop and implement demonstration projects in not fewer than two States, whereby all social security and SSI representative payee applicants would be screened for past convictions through the Federal Bureau of Investigation's Interstate Identification Index.

As part of the demonstration project, the Secretary would be required to determine: (1) the percentage of all representative payee applicants who have been convicted of felony or misdemeanor violations; (2) the type of representative payee applicant (if any) most likely to have a felony or misdemeanor conviction; (3) the suitability of individuals with prior convictions to serve as representative payees; and (4) the circumstances under which such applicants could be allowed to serve as representative payees. A report on the feasibility of implementing the screening procedures for all local offices would be due to the House Ways and Means and the Senate Finance Committees not later than July 1, 1991.

b. Recordkeeping, auditing, and enforcement requirements.—

Conditions for terminating representative payees. The Secretary would be required to terminate payments to a representative payee where the Secretary found that the representative payee had misused the benefit payments.

In addition, the Secretary would be required to maintain a list of those terminated for misuse on or after July 1, 1990, and to provide such list to local field offices.

Listing of representative payees. (1) The Secretary would be required to maintain a computerized list, readily retrievable by field offices, of the social security numbers and addresses of all

representative payees and the social security numbers and addresses of the social security and/or SSI recipients they serve. (2) The local servicing offices would be required to keep a list of all public and community-based nonprofit agencies which are qualified to serve as representative payees and operate in the area served by the local social security office.

High-risk representative payees. The Secretary would be required to study and make recommendations on the desirability and feasibility of adopting stricter accounting requirements for all high-risk representative payees, (serving social security and/or SSI recipients) which include: non-relatives who do not live with the beneficiary; non-relatives who serve 3 or more beneficiaries; and any other group the Secretary determines to be high risk. The provision does not apply to Federal or State governmental institutions.

Demonstration projects relating to provision of information to local agencies providing child and adult protective services. The Secretary would be required to implement demonstration projects in at least 2 states under which the Secretary would provide a list to the state of all addresses where OASDI and SSI benefits are sent to 5 or more individuals. The list would be given to the agency within the state with primary responsibility for regulating care facilities or for providing child and adult protective services. Reports to the House Ways and Means and Senate Finance Committees would be required of the Secretary, including an evaluation and recommendations on the feasibility and desirability of implementing these projects permanently.

c. Report to Congress.—The Secretary would be required to include information in SSA's annual report on the implementation of these representative payee provisions including the number of cases where representative payees were changed; the number of "misuse" cases discovered, how they were dealt with, and their final disposition (including any criminal penalties imposed); and any other information the Secretary determines to be appropriate.

Effective date

Generally, the provisions would be effective on July 1, 1990; those relating to procedures for selection and recruitment of representative payees would be effective for certifications of payment made on or after July 1, 1990. The report on high-risk payees would be due July 1, 1990. The report on the demonstration projects would be due July 1, 1991. Inclusion of representative payee information in SSA's annual report would be required for years after 1989.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House provision.

SUBTITLE B—MEDICARE

PART A—PROVISIONS RELATING TO PART A OF THE MEDICARE PROGRAM

1. Reduction in Payments for Capital-related Costs of Inpatient Hospital Services

Section 10101 of the House Bill, Section 5103 of the Senate Amendment.

Present law

a. Reduction in payments for fiscal year 1990.—Capital-related costs (including depreciation, leases and rentals, interest, and a return on equity for proprietary hospitals) are excluded from Medicare's prospective payment system (PPS) for inpatient hospital services for hospital cost reporting periods beginning before October 1, 1991, and are reimbursed on a reasonable cost basis. The Omnibus Budget Reconciliation Act (OBRA) of 1987 reduced the amounts otherwise payable for capital-related costs for inpatient hospital services by 12 percent for fiscal year 1988 (beginning January 1, 1988), and by 15 percent for fiscal year 1989. Sole community hospitals (SCHs) are exempt from capital payment reductions. Under current law, there will be no reduction in payments for capital-related costs for discharges or portions of cost reporting periods on or after October 1, 1989.

(b) Study of effects of capital-related payments on hospital costs.—No provision.

House bill

(a) Reduction in payments for fiscal year 1990.—Extends the 15 percent reduction in capital-related payments for portions of cost reporting periods or discharges occurring during fiscal year 1990. SCHs remain exempt from capital payment reductions.

(b) Study of effects of capital-related payments on hospital costs.—Requires the General Accounting Office (GAO) to report to Congress by October 1, 1990, the results of a study on the effects of low rates of hospital inpatient occupancy on Medicare costs. The report is to include an analysis of the relationship between fixed and variable hospital costs, and the extent to which closure of unneeded hospital beds or consolidation of inpatient services and facilities could result in savings to the Medicare program.

Effective date

Enactment.

Senate amendment

(a) Reduction in payments for fiscal year 1990.—

Section 5103.—Decreases the reduction in capital-related payments to 13.5 percent for portions of cost reporting periods or discharges occurring during fiscal year 1990. SCHs remain exempt from reductions in capital-related payments; exempts high disproportionate share hospitals eligible for periodic interim payments (PIP) (hospitals with an add-on of 5.1 percent or more in fiscal year 1987) from reductions in capital-related payments.

(b) *Study of effects of capital-related payments on hospital costs.*—No provision.

Effective date

Enactment.

Conference agreement

(a) *Reduction in payments for fiscal year 1990.*—The conference agreement includes the House provision.

(b) *Study of effects of capital-related payments on hospital costs.*—The conference agreement does not include the House provision.

2. *Prospective Payment Hospitals*

Section 10102 of the House bill; sections 5101 and 5102 of the Senate amendment.

Present law

(a) *Reduction in hospital update factors.*—PPS payment rates are updated each year by the use of an "update factor." For FY 1988 and FY 1989, separate update factors have applied to hospitals according to location (large urban, rural, or other urban). Current law would end this distinction after FY 1989. For discharges occurring in FY 1990 and thereafter, the Secretary is required to increase the PPS payment rates by the projected increase in the market basket index, which measures changes in the costs of goods and services purchased by hospitals.

(b) *Annual recalibration of DRG weights on a budget neutral basis.*—The Secretary is required to adjust the DRG definitions and weighting factors each year beginning in FY 1988, to reflect changes in treatment patterns, technology, and other factors affecting the relative use of hospital resources. The payment rate for each DRG consists of a base payment amount for all DRGs, and a relative weighting factor for the particular DRG. The base payment amount is intended to represent the cost of a typical (average) Medicare inpatient case. The relative weighting factor represents the relative costliness of an average case in the particular DRG compared to the cost of the overall average Medicare case.

(c) *Increase in disproportionate share adjustment.*—P.L. 99-272 provided an additional payment to hospitals that serve a disproportionate share of low-income patients from May 1, 1986 to October 1, 1989. P.L. 100-647 extended the provision of such payments until September 30, 1995. The disproportionate patient percentage is defined as the hospital's total number of inpatient days attributable to Medicare beneficiaries who receive Supplemental Security Income (SSI) benefits divided by the total number of Medicare patient days, plus the number of Medicaid patient days divided by the total patient days, times 100.

Urban PPS hospitals with 100 or more beds and rural hospitals with 500 or more beds having a disproportionate patient percentage of at least 15 percent, receive an increase in PPS payments of 2.5 percent, plus 0.5 percentage points for each 1.0 percentage points by which the hospital's disproportionate patient percentage exceeds 15 percent, not to exceed a 15 percent adjustment. Urban

hospitals with fewer than 100 beds and with a disproportionate patient percentage of at least 40 percent receive a payment adjustment of 5 percent. Rural hospitals with fewer than 500 beds and a disproportionate patient percentage of at least 45 percent receive a payment adjustment of 4 percent.

Urban hospitals with 100 or more beds that demonstrate that more than 30 percent of their revenues are derived from State and local government payments for indigent care (excluding payments from Medicare and Medicaid) receive a disproportionate share adjustment of 25 percent.

(d) Increase in update factor for rural hospitals.—See item (a) above.

(e) 3-year extension of regional referral center classification.—Rural hospitals meeting certain criteria may be classified as regional referral centers. Referral centers are paid according to the payment rates for "other" urban areas, rather than the rural rates, adjusted by the hospital's area wage index. The Secretary reviews the status of each referral center every 3 years to determine whether the hospital continues to meet the applicable criteria. OBRA 86 provided that certain hospitals classified as rural referral centers on October 21, 1986, would retain this status through cost reporting periods beginning before October 1, 1989.

(f) Criteria and payment for sole community hospitals.—Sole community hospitals (SCHs) are hospitals that are the sole source of inpatient services reasonably available in a geographic area due to factors such as isolated location, weather conditions, travel conditions, or the absence of other hospitals.

Payment to an SCH is equal to the sum of 25 percent of the Federal DRG rates for the census region in which the SCH is located and 75 percent of a target amount per discharge. The target amount is based on the SCH's costs per case during its cost reporting period beginning in FY 1982, updated to the current year by the update factors used for rural PPS rates.

For cost reporting periods beginning before October 1, 1990, a SCH may request additional payments if it experiences a decrease of more than 5 percent in its total inpatient discharges due to circumstances beyond its control. A hospital may receive such payments if it meets SCH criteria but is not being paid as a SCH; the total amount paid to such hospitals cannot exceed \$5 million in FY 1988 and \$10 million in FY 1989.

A SCH which experiences, in any cost reporting period after the cost reporting period which was used as the base for determining the target amount for payments for the hospital, a significant increase in operating costs attributable to the addition of new inpatient facilities or services, is provided with an adjustment to the payment amounts for such cost reporting period and subsequent cost reporting periods necessary to compensate such hospital for such increased costs.

(g) Geographic classification of hospitals.—A hospital is classified as urban if it is located within an area classified as a Metropolitan Statistical Area (MSA). OBRA 87 provided for the reclassification of a rural hospital as urban if the county in which the hospital is located is adjacent to two or more MSAs, meets certain other criteria, and meets criteria regarding commuting of its employees from

the adjacent rural area to the MSAs. The Secretary has no discretion to modify the definition of urban and rural areas, although current law allows the Secretary the discretion to establish geographic areas for adjusting differentials in wage index levels.

If treating a hospital located in a rural county as being located in an urban area reduces the wage index for that urban area, the Secretary is required to calculate and apply a wage index separately to hospitals located in such urban area (excluding the reclassified hospital). If treating hospitals located in rural counties as not being located in the rural area in a State reduces the wage index for that rural area, the Secretary is required to calculate and apply a wage index as if the hospitals had not been excluded from that rural area. Both adjustments apply only for discharges in FY 1990 and FY 1991.

The Secretary is required to make proportional adjustments in payment rates for urban hospitals to assure that the OBRA 87 provisions do not result in aggregate PPS payments that are greater or less than would otherwise be made, and is further required to adjust payment rates for rural hospitals to ensure that aggregate payments to rural hospitals are not changed by the provisions.

(h) Essential access community hospital demonstration program.—

*(1) Establishment of the program.—*No provision.

*(2) Rural health care transition grants.—*OBRA 87 authorized appropriations from the Medicare Part A Trust Fund of \$15 million a year for FY 1989 and 1990 for the Rural Transition Grant Program, which supports grants to private not-for-profit rural hospitals of up to \$50,000 per year for up to two years for strengthening the financial and managerial ability of isolated and financially distressed rural hospitals. An application for a grant is submitted to the State governor and is then forwarded, with the Governor's comments, to HCFA. No more than one-third of any grant may be spent for capital-related costs.

*(3) Treatment of EACHs as sole community hospitals.—*No provision.

*(4) Coverage of, and payment for, inpatient rural primary care hospital services.—*No provision.

*(5) Avoiding duplicative payments to hospitals participating in rural demonstration programs.—*No provision.

*(i) Study of differences in standardized amounts under the prospective payment system.—*The standardized amounts, which form the basis for DRG payment rates, are different for hospitals in large urban, other urban, and rural areas.

*(j) Uniform reporting requirements for certain hospitals.—*OBRA 87 directed the Secretary to develop a uniform hospital reporting demonstration project in two states (the Secretary selected California and Colorado). In those states, hospitals are required to report hospital statistical and cost information using a uniform reporting format developed by the Secretary.

*(k) Reduction in indirect medical education payments.—*Under PPS, hospitals receive additional payments to compensate for the indirect costs associated with the presence of approved graduate medical education programs (residency training). Indirect costs may be due to factors such as extra demands placed on the hospital

staff by the teaching activity, or additional tests and procedures that may be ordered by residents. Additional payment to teaching hospitals increases with increases in a hospital's ratio of interns and residents to bed size on a curvilinear basis, adding an average discharge adjustment of 7.65 percent for each 0.1 percent increase in the hospital's ratio of interns and residents to beds. The adjustment is scheduled to increase to 8.29 percent in FY 1996, when the disproportionate share adjustment is scheduled to expire.

House bill

(a) *Reduction in hospital update factors.*—Provides the following update factors for discharges occurring during fiscal year 1990: for hospitals in rural areas, the market basket increase minus 0.75 percentage points, for hospitals in large urban areas, the market basket increase minus 1.25 percentage points, and for hospitals in other urban areas, the market basket increase minus 1.75 percentage points. (Item (d), below, changes the factor for rural hospitals to the market basket increase plus 2.0 percentage points.) Beginning in fiscal year 1991, the update factor will be equal to the market basket increase.

(b) *Annual recalibration of DRG weights on a budget neutral basis.*—Requires the Secretary to recalibrate DRG weights for discharges in a fiscal year, beginning with fiscal year 1990, in a manner that does not increase or decrease aggregate PPS payments that would have been made if the DRG weights had not been adjusted.

(c) *Increase in disproportionate share adjustment.*—For urban hospitals with 100 or more beds and rural hospitals with 500 or more beds, increases the disproportionate share adjustment from 0.5 percentage points to 0.6 percentage points for each 1.0 percent by which the hospital's disproportionate patient percentage exceeds 15 percent. For hospitals with a disproportionate patient percentage of over 20.2, the disproportionate share adjustment is further increased to 0.7 percentage points for each 1.0 percent by which the hospital's disproportionate patient percentage exceeds 20.2 percent.

For rural referral centers (see item (e), below) with a disproportionate patient percentage greater than 45 percent, provides a payment adjustment of 4 percent plus 0.6 percentage points for each 1.0 percent by which the hospital's disproportionate patient percentage exceeds 45 percent. For a rural referral center with a disproportionate patient percentage greater than 50.2 percent, further increases the adjustment to 0.7 percentage points for each 1.0 percent by which its disproportionate patient percentage exceeds 50.2 percent.

For hospitals receiving disproportionate share adjustments based on revenue for indigent care from State and local government, provides a disproportionate share adjustment of 30 percent.

(d) *Increase in update factor for rural hospitals.*—Amends the update factor for rural hospitals established by item (a) above to equal the projected increase in the market basket index plus 2.0 percentage points.

(e) *3-year extension of regional referral center classification.*—Extends the classification of regional referral center for all hospitals designated as such on the date of enactment of OBRA 86 (October

21, 1986) through cost reporting periods beginning before October 1, 1992.

(f) Criteria and payment for sole community hospitals.—Defines an SCH as any hospital that the Secretary determines is located more than 35 road miles from another hospital. Hospitals classified as SCHs on the date of enactment that do not meet the new criterion for classification as an SCH may continue to be so classified, but would be paid under the SCH payment provisions in effect prior to enactment.

Provides that payments to SCHs meeting the new criteria are to be determined on a prospective basis for cost reporting periods beginning on or after October 1, 1989, with payments equal to the higher of 100 percent of the SCH's target amount or the applicable PPS rates. Target amounts would be based on the SCH's costs during its cost reporting period beginning in FY 1982 or FY 1987, depending on which, after updating to the current period, produces the higher target amount.

Makes permanent the adjustment provided for SCHs experiencing a decrease of more than 5 percent in a hospital's total number of inpatient cases due to circumstances beyond its control.

Eliminates the adjustment provided for SCHs experiencing a significant increase in operating costs due to the addition of new inpatient facilities or services.

(g) Geographic classification of hospitals.—Requires the Secretary to establish a procedure for hospitals to submit an application requesting a change in the classification of the county in which the hospital is located from rural to urban, or from one urban area to another urban area, or requesting a change in the wage index for the county where the hospital is located. Requires the Secretary to publish instructions for application by hospitals for reclassification within six months of enactment, and approve or disapprove applications within 12 months after receipt from the hospital.

For counties reclassified as a result of the new procedure, provides for adjustments in wage indexes as follows. If reclassifying a county from rural to urban or reclassifying an urban county from one urban area to another urban area reduces the wage index for the area to which the county is reclassified by more than 2 percentage points, the Secretary is required to recalculate and apply separate wage indexes to the other counties located in the area and to the counties that are reclassified. If reclassifying a rural county as not being located in a rural area or reclassifying an urban county from one urban area to another reduces the wage index for the rural area or for other counties located in that urban area, the Secretary is required to calculate and apply the wage index as if the hospitals so reclassified had not been excluded from the calculation of the wage index for the area.

For hospitals reclassified under the OBRA 87 rules, retains the current provisions for adjustment of wage indexes, but provides that the adjustment of an urban area's wage index will apply only if the reclassification of a rural county into that area would reduce its wage index by more than 2 percentage points. (The adjustment provisions for these hospitals continue to apply only to discharges in FY 1990 and 1991; the provisions for hospitals reclassified under the new procedure are permanent.)

Requires the Secretary to make a proportional adjustment in the standardized payment amounts for hospitals located in an urban or rural area to assure that the provisions for reclassification of areas under the new application procedure do not result in aggregate PPS payments that are greater or less than those that would otherwise be made.

Establishes a floor for area wage indices so that the reclassification of hospitals under either the new procedure or the OBRA 87 rules cannot result in the reduction of any county's wage index below the wage index level for other rural areas within the same State.

(h) Essential Access Community Hospital Demonstration Program.—

*(1) Establishment of the program.—*Requires the Secretary to establish an Essential Access Community Hospital (EACH) demonstration program providing grants to up to 10 states. Provides for grants to hospitals and facilities (or consortia of hospitals and facilities) located in States receiving grants for the costs of converting and developing facilities in accordance with the program's requirements. Requires the Secretary to designate hospitals and facilities located in States receiving grants as essential access community hospitals (EACHs) or rural primary care hospitals (RPCBs).

Requires a State grant application to contain assurances that the State is developing or has developed a rural health care plan, in consultation with the State hospital association and rural hospitals, that provides for the creation of one or more rural health networks, promotes regionalization of rural health services in the State, improves access to hospital and other health services for rural residents, and enhances the provision of emergency and other transportation services related to health care. States must designate or be in the process of designating rural non-profit or public hospitals or facilities as EACHs or RPCBs within such networks.

Provides that a hospital or other health facility is eligible to receive grants if it is located in a State receiving a grant and is designated as an EACH or RPCB, or is a member of a rural health network. The hospital must file an application with the State and the Secretary, and the State must certify that the receipt of such a grant by the hospital or facility is consistent with the State's rural health care plan. A consortium of hospitals or facilities each of which is part of the same rural health network is eligible to receive a grant if each member would be individually eligible to receive a grant.

Permits States to use grants to plan and implement a rural health care plan and rural health network, designate hospitals or facilities as EACHs or RPCBs, and develop and support communication and emergency transportation systems. Grants to hospitals or health facilities can be used to finance the costs of converting to a rural primary care hospital or becoming part of a rural health network, including capital costs, costs incurred in the development of necessary communications systems, and costs incurred in the development of an emergency transportation system. A consortium can use a grant to finance

the costs it incurs in converting hospitals or facilities that are part of the consortium into rural primary care hospitals or in developing and implementing a rural health network.

Provides that a State may designate a hospital as an EACH facility if it is located in a rural area, is more than 35 miles from any hospital designated as an EACH or a rural referral center, has at least 75 beds or is located more than 35 miles from any other hospital. An EACH must also agree to provide emergency and medical backup services to RPCHs participating in the rural health network of which the EACH is a member, provide staff privileges to RPCH physicians, and accept patients transferred from RPCHs.

Provides that a State may designate a facility as an RPCH only if the facility is located in a rural area, is in compliance with Medicare conditions of participation at the time it applies, and agrees to cease providing inpatient care except as specified below. An RPCH must also participate in the network's communication and data sharing systems, provide 24-hour emergency care, and have no more than 6 inpatient beds for providing temporary inpatient care for periods of 72 hours or less to patients requiring stabilization before discharge or transfer to another hospital. An RPCH is required to meet the staffing requirements of other rural hospitals, but need not meet standards for hours or days of operation, as long as it meets the requirement to provide 24-hour emergency care. Services of a dietician, pharmacist, laboratory technician, medical technologist, or radiological technologist may be furnished on a part-time, off-site basis, and required inpatient care may be provided by a physician's assistant or nurse practitioner, subject to oversight of a physician. An RPCH is required to maintain clinical records on all patients, make arrangements with one or more hospitals for the referral and admission of patients requiring services not available at the RPCH, have a physician, physician assistant or nurse practitioner available to provide services, provide routine diagnostic services, dispense drugs and biologicals in compliance with State and Federal law, have appropriate procedures for review of utilization of clinic services, and meet any other requirements the Secretary may determine are necessary.

Requires States to give preference to hospitals or facilities that are participating in a rural health network when designating facilities as rural primary care hospitals. Defines a rural health network as an organization consisting of at least one hospital that is an EACH, is a rural referral center, or is located in an urban area and meets the criteria for classification as a regional referral center, and at least one facility that is an RPCH. Requires members of a rural health network to have entered into agreements regarding patient referral and transfer, the development and use of communications systems, including (where feasible) telemetry systems and systems for electronic sharing of patient data, and the provision of emergency and non-emergency transportation among the members of the network.

Limits grants to a hospital or facility to \$200,000.

Requires the Secretary to designate a hospital as an EACH if the hospital is located in a State receiving a grant, has been designated by the State as an EACH, and meets other criteria as the Secretary may require. Permits the Secretary to designate a hospital as an EACH if it would have been so designated by the State but for the fact that it has fewer than 75 beds or is within 35 miles of another hospital.

Requires the Secretary to designate a hospital as a rural primary care hospital if the facility is located in a State receiving a grant, is designated as a rural primary care hospital by the State, and meets such other criteria as the Secretary requires. A facility that is not eligible for designation as a rural primary care hospital solely because it is not designated as a rural primary care hospital by the State, may be so designated by the Secretary if it was not designated as a rural primary care hospital by the State solely because of its failure to meet one of the following criteria: ceasing or agreeing to cease providing inpatient care; providing not more than 6 inpatient beds for care not to exceed 72-hours to patients requiring stabilization; or, meeting minimum staffing requirements.

Authorizes appropriations from the Hospital Insurance Trust Fund of \$15 million a year for grants to States and \$15 million a year for grants to hospitals, facilities and consortia for FY 1990, 1991, and 1992.

(2) *Rural health care transition grants.*—Provides that hospitals receiving grants on or after October 1, 1989 under the Rural Health Care Transition Program may use the grant to develop a plan for converting to a RPCH or to develop a rural health network if located in a State receiving an EACH grant. Waives the capital expenditure limit when a grant is used for this purpose. Provides that a grant application is to be submitted directly to HCFA, with a copy to the State Governor for comment. Authorizes the appropriation of \$10 million a year from the Hospital Insurance Trust Fund for grants to hospitals for FY 1990, 1991, and 1992.

(3) *Treatment of EACHs as sole community hospitals.*—Provides that a hospital designated by the Secretary as an EACH is to be treated as a sole community hospital for payment purposes. Provides that, if an EACH incurs increases in reasonable costs during a cost reporting period and will incur such increases in subsequent cost reporting periods as a result of becoming a member of a rural health network, the hospital's target amount will be increased to account for the increased costs.

(4) *Coverage of, and payment for, inpatient rural primary care hospital services.*—Includes inpatient RPCH services as a covered service under Part A of Medicare. Defines these services as inpatient services provided by a designated RPCHs that would be inpatient hospital services if provided by a hospital. Provides that payment maybe made only if a physician certifies that inpatient RPCH services were required to be immediately furnished on a temporary, inpatient basis.

Makes conforming amendments relating to development of conditions of participation for RPCHs and use of State licens-

ing agencies or national accrediting bodies to determine RPCH compliance.

Provides that payment for inpatient RPCH services in the first 12-month cost reporting period of operation is the reasonable costs of the facility in providing such services determined on a per diem basis. Payment for later reporting periods is the per diem payment amount for the preceding 12-month cost reporting period, increased by the PPS update factor for rural hospitals. Requires the Secretary to develop a prospective payment system for inpatient rural primary care hospital services on or after January 1, 1993.

(5) Avoiding duplicative payments to hospitals participating in rural demonstration programs.—Requires the Secretary to reduce payment amounts to hospitals and RPCHs participating in EACH demonstrations to the extent necessary to avoid duplication of any payment made under demonstration grants or the Rural Health Care Transition Grant Program.

(i) Study of Differences in Standardized Amounts Under the Prospective Payment System.—Requires the Secretary to report to the House Committee on Ways and Means, Senate Committee on Finance, and Prospective Payment Assessment Commission (ProPAC) by October 1, 1990, on the results of a study analyzing the current differences in the standardized amounts under PPS among large urban, other urban, and rural areas, and evaluating whether the differences in the amounts could be eliminated by expanding or revising the current method used to determine or update such amounts.

The report is required to include recommendations regarding the establishment of a single national rate for PPS hospitals, the need for appropriate adjustments in payment rates to reflect severity of illness among patients classified in the same DRG or to reflect other differences in costs within a DRG, and other adjustments the Secretary deems appropriate.

Requires ProPAC to submit a report to the House Committee on Ways and Means and the Senate Committee on Finance by April 1, 1991, evaluating the Secretary's recommendations.

(j) Uniform reporting requirements for certain hospitals.—Requires hospitals receiving disproportionate share adjustments, regional referral centers, sole community providers, and EACH facilities to report statistics and cost information using the uniform reporting format developed by the Secretary in the hospital reporting demonstration project created by OBRA 87.

(k) Reduction in indirect medical education payments.—No provision.

Effective date

(a), (b), (d), (e), (h), (i) enactment; (c) applies to discharges occurring on or after October 1, 1989; (f), (j) apply to cost reporting periods beginning on or after October 1, 1989; (g) is effective on enactment, except that the provision establishing a floor for area wage indices applies to payments for discharges occurring on or after October 1, 1989.

Senate amendment

(a) Reduction in hospital update factors.—

Section 5101.—Provides the following update factors for discharges occurring during FY 1990: for hospitals in rural areas, the market basket increase plus 3.0 percentage points, for hospitals in large urban areas, the market basket increase minus 0.7 percentage points, for hospitals in other urban areas, the market basket minus 1.4 percentage points.

(b) Annual recalibration of DRG weights on a budget neutral basis.—No provision.

(c) Increase in disproportionate share adjustment.—No provision.

(d) Increase in update factor for rural hospitals.—Increases update factor for rural hospitals to equal the projected increase in the market basket index plus 3.0 percentage points; see item (a) above.

(e) 3-year extension of regional referral center classification.—No provision.

(f) Criteria and payment for sole community hospitals.—No provision.

(g) Geographic classification of hospitals.—No provision.

(h) Essential access community hospital demonstration Program.—No provision.

(i) Study of differences in standardized amounts under the prospective payment system.—No provision.

(j) Uniform reporting requirements for certain hospitals.—No provision.

(k) Reduction in indirect medical education payments.—Reduces the indirect medical education adjustment for FY90 to an average of 7.1 percent for each 0.1 percent increase in the hospital's ratio of interns and residents.

Effective date

(a) Enactment. (k) applies to payments for discharges occurring on or after October 1, 1989.

Conference agreement

(a) Changes in hospital update factors.—The conference agreement continues, for all Part A services, the reductions in payment imposed under the sequester order of October 16, 1989, pursuant to the Balanced Budget and Emergency Deficit Control Act of 1985 (Gramm-Rudman-Hollings) through December 31, 1989. The agreement provides that no additional reduction in payments under Part A would occur as a result of a new sequester order under Title 11 of the Act. This would be accomplished by increasing payments under Part A to providers for items or services provided on or after January 1, 1990 by a percentage amount (1.42%) equal to the amount of the reduction imposed pursuant to an order under Title 11 for those providers affected by the order.

The agreement provides the following update factors for discharges occurring on or after January 1, 1990, and before October 1, 1990: for hospitals in rural areas, the market basket increase plus 4.22 percent; for hospitals in large urban areas, the market basket increase plus 0.12 percent; for hospitals in other urban

areas, the market basket increase minus 0.53 percent. For the purpose of computing payment rates for FY 1991 and later years, the update factors for FY 1990 will be deemed to have been those in effect beginning January 1, 1990.

The agreement provides for a PPS pass-through payment for the costs of administering blood clotting factors to individuals with hemophilia.

The Prospective Payment Assessment Commission is required to include as part of its June 1, 1990 report to Congress a study of the appropriateness of making an adjustment to the methodology for determining PPS payments for hospitals with a high proportion of Medicare discharges. The conferees also request that ProPAC include in its June 1 report an analysis of the financial status of high case mix hospitals, with special attention devoted to capital investment in these hospitals as compared with other hospitals.

(b) Annual recalibration of DRG weights on a budget neutral basis.—The conference agreement requires the Secretary to reduce the weighting factor for each DRG by 1.22 percent for discharges in FY 1990. As a result of this provision and the update factors, the net update in PPS payment rates effective January 1, 1990, will be as follows: for hospitals in rural areas, the market basket increase plus 3.0 percent; for hospitals in large urban areas, the market basket increase minus 1.1 percent; for hospitals in other areas, the market basket increase minus 1.75 percent. The provision prohibits Secretary of HHS from adjusting DRG weighting factors on other than a budget neutral basis effective in FY 91.

(c) Increase in disproportionate share adjustment.—The conference agreement includes the House provision, with amendments. The increase in the disproportionate share adjustment for urban hospitals with more than 100 beds and a disproportionate patient percentage of over 20.2 percent is set at 0.65 percentage points for each 1.0 percent by which the hospital's disproportionate patient percentage exceeds 20.2 percent. For rural hospitals with more than 100 beds and hospitals classified as sole community hospitals, the disproportionate patient percentage required to qualify for a payment adjustment is reduced to 30 percent. For sole community hospitals the amount of the payment adjustment is increased to 10 percent. The formula for rural referral centers is $(P-30) (.6) + 4.0$. Hospitals that are classified as both sole community and rural referral centers will receive the higher of the applicable adjustments. The changes are effective for discharges occurring on or after April 1, 1990.

(d) Increase in update factor for rural hospitals.—See (a) above.

(e) 3-year extension of regional referral center classification.—The conference agreement includes the House provision, with an amendment to provide that the extension applies to all hospitals classified as regional referral centers as of September 30, 1989, including those so classified as a result of OBRA 1986.

(f) Criteria and payment for sole community hospitals.—The conference agreement includes the House provision, with amendments. The Secretary retains the authority to classify as an SCH a hospital that is fewer than 35 miles from another hospital but that meets other criteria established by the Secretary. The Secretary is required to develop and promulgate new criteria based on travel

time. The new payment provisions established for SCHs that are more than 35 miles from another hospital are extended to apply to all SCHs. The hospital receives the higher of three rates as the basis for reimbursement: a target amount based on the hospital's 1982 costs, a target amount based on the hospital's 1987 costs, or the Federal PPS rate. The provisions apply to cost reporting periods beginning on or after April 1, 1990.

The agreement also applies the new payment provisions to rural hospitals that are not SCHs, but that have 100 or fewer beds and depend on Medicare for at least 60 percent of their patient days or discharges. For these hospitals, the payment provisions apply only to cost reporting periods beginning on or after April 1, 1990, and ending on or before March 31, 1993. These hospitals will also be eligible for the volume adjustment provided for SCHs. Eligibility for this provision will be determined based on data from cost reports beginning in fiscal year 1987.

The agreement also requires the Prospective Payment Assessment Commission (ProPAC) to study and report on the feasibility of returning small rural hospitals to cost-based reimbursement, developing alternative measures of market share for use in classifying sole community hospitals, and the feasibility of applying a volume adjustment to the payment of small rural hospitals.

(g) Geographic classification of hospitals.—The conference agreement includes the House provision with amendments to provide for a board to review and modify the geographic status of hospitals. The provision also amends the provisions for adjustment of wage indexes and standardized amounts to allow for the reclassification of hospitals under OBRA 1987, to provide that if the addition of hospitals located in a rural county to an urban area reduced the wage index for the urban area by more than one percentage point, the rural county would be treated as if it were a separate urban area. If the addition of the rural county to the urban area reduced the wage index of the urban area by less than one percentage point, the calculation of the wage index for the combined area would exclude the wage costs of the rural county. The amendment also provides that the wage index for a rural county affected by this provision could not be less than the rural wage index for the state in which the county was located. The amendment applies to discharges on or after April 1, 1990. The adjustments made by this section would be required to be made on a budget neutral basis.

The agreement further requires that the Secretary update the area wage index annually, beginning in FY 1993. Such updates will be budget neutral.

The agreement also provides for additional payment to hospitals adversely affected by errors in the computation of the area wage index resulting from erroneous data submitted by hospitals in response to the 1984 HCFA wage survey. A hospital will be eligible for the additional payment if it was not one of the hospitals that submitted erroneous data, and if correction of the error results in an adjustment of the wage index of at least 3 percentage points. Additional payment is available only for discharges during periods when the erroneously determined wage index was in effect.

(h) Essential Access Community Hospital Demonstration Program.—The conference agreement follows the House bill with

amendments to reduce the number of grants to states to seven and reduce the authorization for grants to states to \$10 million. The authorization for rural health care transition grants is increased to \$25 million and telecommunications projects are added as a purpose for which grants may be awarded. The provision also authorizes the Secretary to designate up to 15 facilities as Rural Primary Care Hospitals in States which do not participate in the EACH program. In designating this group of facilities, the Secretary may waive the requirements that restrict the provision of inpatient care. The Secretary is further authorized to waive any provisions of Part A of Medicare in order to further the purposes of the program.

The conferees wish to clarify with respect to the rural health care transition grant program that the Secretary is authorized to set priorities among the several uses for grant funds authorized by law.

(i) *Study of differences in standardized amounts under the prospective payment system.*—The conference agreement includes the House provision with an amendment to require the Secretary to develop a legislative proposal regarding elimination of separate standardized amounts for rural, other urban, and large urban hospitals.

(j) *Uniform reporting requirements for certain hospitals.*—The conference agreement does not include the House provision.

(k) *Reduction in indirect medical education payments.*—The conference agreement does not include the Senate amendment.

3. PPS-Exempt Hospitals

Section 10103 of the House bill.

Present law

(a) *Exemption of cancer hospitals from prospective payment system.*—The Secretary is authorized to provide for exceptions or adjustments in PPS for hospitals extensively involved in treatment for and research on cancer. Currently, hospitals so designated may elect to be paid on a reasonable cost basis. However, they are treated similarly to PPS hospitals for purposes of periodic interim payments (PIP) and for capital-related payments.

(b) *Rebasing for certain non-PPS hospitals.*—PPS-exempt hospitals are reimbursed using a system of target amounts which are defined as the hospital's base-year costs inflated by a rate of increase limit. Hospitals below the target amount receive a bonus. The current base year for determining target amounts is generally cost reporting periods beginning in fiscal year 1982.

(c) *Publication of instructions relating to exceptions and adjustments in target amounts.*—The Secretary is directed to provide an exemption from, or an exception and adjustment to a hospital's target rate if events beyond the hospital's control, or extraordinary circumstances, including changes in case mix, cause a distortion in the hospital's base year costs or annual cost increases.

House bill

(a) *Exemption of cancer hospitals from prospective payment system.*—Exempts from PPS hospitals classified before December 31, 1990, as extensively involved in treatment for or research on cancer.

(b) *Rebasing for certain non-PPS hospitals.*—Amends the base year for determining target amounts for cancer hospitals to be cost reporting periods beginning in fiscal year 1987, unless the use of a 1982 base and the intervening updates between 1983 and 1987 creates a higher target amount. The higher target amount will be used as the base.

(c) *Publication of instructions relating to exceptions and adjustments in target amounts.*—Requires the Secretary to publish instructions within 180 days after enactment specifying the application process to be used in providing exceptions and adjustments in target amounts for hospitals.

Effective date

(a) Applies to cost reporting periods beginning on or after October 1, 1989, in the case of hospitals already classified as cancer hospitals on the date of enactment. For such hospitals, changes in capital reimbursement apply to portions of cost reporting periods or discharges occurring during and after fiscal year 1987; eligibility for PIP is effective 30 days after enactment. For hospitals classified as cancer hospitals after enactment, the provisions apply to cost reporting periods beginning on or after the date of such classification. (b) Applies to cost reporting periods beginning on or after October 1, 1989. (c) Enactment.

Senate amendment

No provision.

Conference agreement

(a) *Exemption of cancer hospitals from prospective payment system.*—The conference agreement includes the House provision, with an amendment. An exemption is also provided for any hospital classified as a cancer hospital before December 31, 1991, that is located in a State that has a PPS waiver under section 1814(b) as of the date of enactment.

(b) *Rebasing for certain non-PPS hospitals.*—The conference agreement includes the House provision, except that the changes apply to cost reporting periods beginning on or after April 1, 1989.

(c) *Publication of instructions relating to exceptions and adjustments in target amounts.*—The conference agreement includes the House provision with an amendment to authorize the Secretary to determine a hospital's target amount using a new base year.

4. Payments for Hospice Care

Section 10111 of House bill.

Present law

Medicare Part A beneficiaries, who are certified as terminally ill by a physician within 2 days after their care is initiated, may elect

to receive hospice benefits, in lieu of certain other Medicare covered services. Beneficiaries electing hospice are entitled to receive hospice services for two 90-day periods and one subsequent 30-day period, and another period beyond this total of 210 days of coverage so long as the beneficiary's physician or hospice medical director recertifies that the beneficiary is still terminally ill.

In implementing the hospice benefit, HHS established a prospective payment system for hospice care. Under this payment system, hospices are paid one of four predetermined rates for each day a Medicare beneficiary is under the care of the hospice. The rates vary according to the level of care furnished to the beneficiary. The rates are as follows: (1) routine home care—\$63.17; (2) continuous home care—up to \$368.67; (3) inpatient respite care day—\$65.33; and (4) general inpatient care—\$281.00.

These rates were increased to their present levels in 1986 by COBRA of 1985, P.L. 99-272. At that time, COBRA increased each of the four payment rates by \$10 a day. COBRA also provided the Secretary of HHS an additional year (until October 1, 1986) for the first annual review and adjustment of hospice payment rates.

House bill

(a) *Increase in current rates.*—Increases hospice payment rates by 20 percent effective October 1, 1989, and requires that payment rates be increased in subsequent fiscal years by increases in the hospital market basket.

(b) *Study of methods to compensate hospices for high-cost care.*—Requires the Secretary of HHS to conduct a study of high-cost hospice care provided to Medicare beneficiaries and to evaluate the ability of hospice programs participating in Medicare to provide this care. Based on this study, also requires the Secretary to develop methods to compensate hospices for high-cost care provided to Medicare beneficiaries. Requires the Secretary to report on the study and any recommendations for compensating hospice for high-cost care by October 1, 1990.

Effective date

Enactment.

Senate amendment

No provision.

Conference agreement

(a) *Increase in current rates.*—The conference agreement includes the House provision, with an amendment. The requirement that persons be certified as terminally ill within 2 days after hospice care is initiated is amended to specify that certification occur not later than 8 days after care is initiated, if verbal certification is provided within 2 days. The provisions are effective for care and services furnished on or after January 1, 1990.

(b) *Study of methods to compensate hospices for high-cost care.*—The conference agreement includes the House provision.

5. Miscellaneous Technical Provisions Relating to Part A

Section 10112 of the House bill.

Present law

(a) *Hospital obligations with respect to treatment of emergency medical conditions and indigent care.*—As a condition of participation in Medicare, hospitals are required to comply, to the extent applicable, with requirements relating to the examination and treatment for emergency medical conditions and women in active labor. Hospitals are currently not required to inform patients of these obligations.

When transferring patients, hospitals are required to provide to the receiving facility the appropriate medical records (or copies of them) of the examination and treatment provided at the transferring hospital.

Medicare participating hospitals are not required to participate in the Medicaid program, nor inform patients if they participate in the Medicaid program.

The Prospective Payment Assessment Commission is required by law to collect and assess information on various aspects of health care. There is no requirement in current law that the Prospective Payment Assessment Commission determine the amount of uncompensated care provided by hospitals.

(b) *Medicare buy-in for continued benefits for disabled individuals.*—Social Security Disability Insurance (SSDI) beneficiaries who return to work, but do not medically recover, stop receiving cash benefits after a twelve month period, and stop receiving Medicare benefits after an additional thirty-six months of extended eligibility are exhausted.

(c) *Release and use of hospital accreditation surveys.*—A hospital may be deemed to meet Medicare's participation requirements if it is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). HCFA performs validation surveys of JCAHO approved hospitals on a sample basis or if allegations about quality problems at a specific hospital are made. A hospital must agree to authorize JCAHO to release a copy of the hospital's most current accreditation survey if the hospital is the subject of a validation survey by HCFA. The Secretary is prohibited from disclosing any accreditation survey made and released by JCAHO.

If the Secretary finds that a hospital has serious deficiencies in quality or safety following a validation survey, the hospital may no longer be deemed to meet Medicare's participation requirements and removed from the program.

(d) *Intermediate sanctions for psychiatric hospitals.*—Current law provides for intermediate sanctions to be imposed on skilled nursing facilities that fail to meet the requirements for participation, but has no such provisions for inpatient psychiatric hospitals.

(e) *Medical necessity certification of extended care services by nurse practitioners and clinical nurse specialists.*—Medicare specifies that payment for skilled nursing facility (SNF) care can be made only if a physician certifies (and recertifies where care is provided over a period of time) that an individual needs, on a daily

basis, skilled nursing care or other skilled rehabilitation services that can only be provided in a SNF.

(f) Eligibility of merged or consolidated hospitals for periodic interim payments.—A PPS hospital may generally receive periodic interim payments (PIP) only if the hospital had a disproportionate share adjustment percentage of at least 5.1 during FY 1987 or was a rural hospital with less than 100 beds, and was receiving PIP as of June 30, 1987.

(g) Extension of waiver for Finger Lakes Area Hospitals Corporation.—The Secretary may provide that payment with respect to services provided by a hospital in a State may be made in accordance with a hospital reimbursement control system in a State, rather than under Medicare's reimbursement system.

For State reimbursement systems approved by the Secretary prior to the enactment of the Social Security Amendments of 1983, the Secretary is required to continue to use the State system if the State so requests and, for the first three cost reporting periods beginning on or after October 1, 1983, the increase in payments for hospital inpatient care under the State system does not exceed the increase under the national system. After the three year period, the Secretary may choose to evaluate the State system based on whether, during 36-month periods, the amount of payments to hospitals under the State system will not exceed those which would have been made under Medicare's reimbursement system.

Currently, Maryland and New York have such waivers, although the New York waiver covers only the four counties participating in the Finger Lakes Area Hospitals Corporation (FLAHC) rural hospital payment demonstration.

(h) Clarification of continuation of August 1987 hospital bad debt recognition policy.—Under current regulations the Medicare program makes payments to hospitals to reimburse hospitals for Medicare bad debt, defined as unrecovered costs associated with unpaid Medicare deductible and coinsurance. The bad debt must be related to covered services furnished to a Medicare beneficiary in order to be considered bad debt and the hospital is required to meet certain collection criteria.

OBRA 87 directed the Secretary to continue payments for Medicare bad debt under policy in effect as of August 1, 1987. The Technical and Miscellaneous Revenue Act of 1988 further specified that criteria for indigency determination procedures, for record keeping, and for determining whether to refer a claim to an external collection agency were among the elements of 1987 policy not subject to change.

(i) Use of more recent data regarding routine service costs of skilled nursing facilities.—Medicare law authorizes the Secretary of HHS to set limits on skilled nursing facility (SNF) routine service costs that will be recognized as reasonable and reimbursed under the program. The Secretary is required to establish separate per diem limits for freestanding and hospital-based SNFs as follows: For freestanding SNFs in urban and rural areas, the limits are set at 112 percent of the mean routine service costs of urban and rural freestanding facilities, respectively. Limits for urban and rural hospital-based facilities are set at the appropriate freestanding limit, plus 50 percent of the difference between the freestand-

ing limit and 112 percent of the mean routine service costs for hospital-based facilities. An amount is added to the hospital-based facility limit to account for cost differences between hospital-based and freestanding SNFs that are attributable to excess overhead allocations resulting from Medicare reimbursement principles.

The current schedule of Medicare cost limits for SNFs is based on cost reports submitted by SNFs for cost reporting periods ending between October 1, 1982 and September 30, 1983.

(j) *Permitting dentist to serve as hospital medical director.*—Medicare regulations require as a condition of participation for hospitals that the responsibility for organization and conduct of the medical staff be assigned to a doctor of medicine or osteopathy.

(k) *GAO study of hospital-based and freestanding skilled nursing facilities.*—Medicare requires the Secretary of HHS to establish separate limits on the routine service costs of freestanding and hospital-based skilled nursing facilities (SNFs). For freestanding SNFs in urban and rural areas, the limits are set at 112 percent of the mean routine service costs of urban and rural freestanding facilities, respectively. Limits for urban and rural hospital-based facilities are set at the appropriate freestanding limit, plus 50 percent of the difference between the freestanding limit and 112 percent of the mean routine service costs for hospital-based facilities. An amount is added to the hospital-based facility limit to account for cost differences between hospital-based and freestanding SNFs that are attributable to excess overhead allocations resulting from Medicare reimbursement principles.

House bill

(a) *Hospital obligations with respect to treatment of emergency medical conditions and indigent care.*—

(1) *In general.*—Requires a hospital or rural primary care hospital participating in Medicare to: (a) adopt and enforce a policy to ensure compliance with requirements relating to the examination and treatment of emergency medical conditions and women in active labor; (b) maintain medical and other records related to individuals transferred to or from the hospital for a period of five years from the date of transfer; and (c) maintain a list of physicians who are on call for duty after the initial examination to provide treatment necessary to stabilize an individual with an emergency medical condition. Requires that each Medicare participating hospital post conspicuously in any emergency department a sign (in a form specified by the Secretary) specifying the rights of individuals to emergency treatment, and to post conspicuously (in a form specified by the Secretary) information indicating whether or not the hospital participates in Medicaid.

(2) *GAO survey.*—Requires the General Accounting Office to determine, through a survey or other appropriate means, for each hospital participating under the Medicare program, the hospital's policy regarding the treatment of individuals eligible for Medicaid benefits, and the percentage of the hospital's revenue attributable to Medicaid payments. Requires the Comptroller General to submit a report no later than one year after

enactment to the House Ways and Means and Senate Finance Committees.

(3) *Determining uncompensated care.*—Requires that no later than one year after enactment, the Prospective Payment Assessment Commission develop a method for determining the amount of uncompensated care provided by a hospital and to submit a report describing such method to the House Ways and Means and Senate Finance Committees.

Effective date

(a)(1) is effective the first day of the first month that begins more than 180 days after enactment, without regard to whether implementing regulations have been promulgated by that date; (a) (2) and (3): enactment.

(b) *Medicare buy-in for continued benefits for disabled individuals.*—Provides disabled beneficiaries who are not yet 65 years old and continue to be disabled, and who are no longer entitled to benefits solely because of having earnings in excess of the amount permitted, with the option of purchasing Medicare coverage after they have worked a full forty-eight months and have exhausted their extended period of Medicare eligibility.

Provides that an individual may only enroll during a 7-month enrollment period, that begins after an individual is notified that entitlement to benefits will end, or during a general annual enrollment period between January 1 and March 31 beginning in 1990. Entitlement to benefits begins based on when the individual becomes eligible to receive benefits and enrolls for such benefits. Entitlement is delayed for individuals enrolling after the first month in which they become eligible. An individual's coverage period continues until enrollment is terminated because the individual is no longer disabled, the individual files notice of no longer wishing to participate, the individual becomes otherwise eligible for hospital insurance coverage under Medicare, or the individual stops paying premiums. Permits the Secretary to establish a grace period before termination for non-payment.

Requires that premiums be paid as prescribed in regulations, and that premiums collected be deposited in the Treasury and credited to the Federal Hospital Insurance Trust Fund. Premiums are payable for the first month of an individual's enrollment and until the month of the individual's death or termination of an individual's coverage period. Requires the amount of monthly premiums to be the same as premiums charged for Medicare's hospital insurance benefits for uninsured individuals and provides that for purposes of Medicare catastrophic premiums, enrollees shall be treated in the same way as such uninsured individuals.

Effective date

Enactment, except that does not apply so as to provide hospital insurance coverage for any month before July 1990.

(c) *Release and use of hospital accreditation surveys.*—Provides that a hospital may be deemed to meet Medicare requirements on the basis of JCAHO accreditation only if JCAHO releases to the Secretary all copies of all accreditation surveys and other relevant

information. Requires that JCAHO survey information be released even if the hospital is not the subject of a HCFA validation survey.

Authorizes the Secretary to disclose surveys and related information to the extent that such information relates to an enforcement action taken by the Secretary.

Permits the Secretary to determine that a hospital does not meet participation requirements on the basis of information other than information derived from a validation survey.

Effective date

Enactment, except that provisions relating to hospital and JCAHO release of information apply 6 months after enactment.

(d) *Intermediate sanctions for psychiatric hospitals.*—If the Secretary determines that a psychiatric hospital fails to meet Medicare's participation requirements and these deficiencies immediately jeopardize the health and safety of its patients, the Secretary is required to terminate the hospital's Medicare participation agreement. If there is no immediate jeopardy to the health and safety of the patients, the Secretary may choose to terminate Medicare's participation agreement with the hospital or deny Medicare payments for individuals admitted after the effective date of the finding, or both.

If non-compliance continues for 3 months after the initial finding, the Secretary must deny Medicare payments for new admissions. If the non-compliance continues for 6 months, the Secretary must deny Medicare payments until the hospital achieves compliance.

Effective date

Enactment.

(e) *Medical necessity certification of extended care services by nurse practitioners and clinical nurse specialists.*—Authorizes nurse practitioners and clinical nurse specialists working in collaboration with a physician to certify and recertify the need for SNF care.

Effective date

Enactment.

(f) *Eligibility of merged or consolidated hospitals for periodic interim payments.*—Provides that a hospital created by the merger or consolidation of 2 or more hospitals or hospital campuses shall be eligible to receive PIP if at least one of the hospitals or campuses received PIP prior to the merger or consolidation, and the merging or consolidating hospitals or campuses would each meet the requirement of having a disproportionate share adjustment percentage of at least 5.1 percent during FY 1987 if treated as independent hospitals.

Effective date

Applies to payments made for discharges occurring on or after October 1, 1989, regardless of the date of the merger or consolidation of the facilities involved.

(g) *Extension of waiver for Finger Lakes Area Hospitals Corporation.*—Requires the Secretary's test of the effectiveness of a State cost containment system to be based on the aggregate rate of in-

crease from October 1, 1984, to the most recent date for which annual data are available.

Effective date

Enactment.

(h) Clarification of continuation of August 1987 hospital bad debt recognition policy.—Amends OBRA 87 by prohibiting the Secretary from requiring a hospital to change its bad debt collection policy if a fiscal intermediary accepted the policy in accordance with the rules in effect as of August 1, 1987, for indigency determination procedures, for record keeping, and for determining whether to refer a claim to an external collection agency. For such facilities, the Secretary also may not collect from the hospital on the basis of an expectation of a change in the hospital's collection policy.

Effective date

Effective as if included in the enactment of OBRA 87.

(i) Use of more recent data regarding routine service costs of skilled nursing facilities.—Requires the Secretary to use for SNF cost limits cost reports submitted by SNFs for cost reporting periods ending September 30, 1986.

Effective date

Enactment.

(j) Permitting dentist to serve as hospital medical director.—Permits a doctor of dental surgery or of dental medicine to serve as a hospital's medical staff director, if permitted under State law.

Effective date

Enactment.

(k) GAO study of hospital-based and freestanding skilled nursing facilities.—Requires GAO to conduct a study to assess the differences in costs and case-mix between hospital-based and freestanding SNFs participating in Medicare. Requires GAO to report to Congress on this study and its recommendations, including recommendations on the payment differential between hospital-based and freestanding SNFs, by June 1, 1990.

Effective date

Enactment.

Senate amendment

No provision.

Conference agreement

(a) Hospital obligations with respect to treatment of emergency medical conditions and indigent care.—The conference agreement includes the House provision with an amendment to delete studies by the General Accounting Office and the Prospective Payment Assessment Commission.

(b) Medicare buy-in for continued benefits for disabled individuals.—The conference agreement includes the House provision.

The conference agreement also provides that the Secretary shall at the request of a State made after 1989, modify the buy-in agree-

ment with the State to provide for State payment of Part A premiums for qualified Medicare beneficiaries.

(c) *Release and use of hospital accreditation surveys.*—The conference agreement includes the House provision.

(d) *Intermediate sanctions for psychiatric hospitals.*—The conference agreement includes the House provision.

(e) *Medical necessity certification of extended care services by nurse practitioners and clinical nurse specialists.*—The conference agreement includes the House provision with an amendment to require that nurse practitioners or clinical nurse specialists not have a direct or indirect employment relationship with the facility.

(f) *Eligibility of merged or consolidated hospital for periodic interim payment.*—The conference agreement includes the House provision.

(g) *Extension of waiver for Finger Lakes Area Hospitals Corporation.*—The conference agreement includes the House provision.

The conference agreement also provides that no recoupment or reduction may be made in payments to Massachusetts hospitals on account of alleged overpayments prior to May 1, 1990.

(h) *Clarification of continuation of August 1987 hospital bad debt recognition policy.*—The conference agreement includes the House provision.

(i) *Use of more recent data regarding routine service costs of skilled nursing facilities.*—The conference agreement includes the House provision.

The conference agreement also includes a provision prohibiting balance billing by nursing homes to Medicare patients.

(j) *Permitting dentist to serve as hospital medical director.*—The conference agreement includes the House provision.

(k) *GAO study of hospital-based and freestanding skilled nursing facility.*—The conference agreement includes the House provision.

PART B—PROVISIONS RELATING TO PART B OF THE MEDICARE PROGRAM

1. Physician Payment Reform

Sections 10123 and 4001 of House bill.

Present law

(a) *In general.*—Medicare pays for physicians' services on the basis of reasonable charges. The reasonable charge for a service cannot exceed the physician's actual charge, the physician's customary charge, or the prevailing charge for the service in the community. Customary and prevailing charge fee screens (i.e. benchmarks against which individual charges are compared) are updated annually. The increase in the prevailing charge screen is subject to a limitation known as the Medicare Economic Index (MEI). The MEI is a limitation on cumulative changes in prevailing charges since 1973. Recently, allowable MEI increases have been specified by law.

Medicare pays 80 percent of the reasonable charge after the beneficiary has met the \$75 deductible. Medicare payments are made directly to the physician or the patient depending on whether the physician has accepted assignment for the claim. In the case of assigned claims, the physician bills the program directly and is paid

an amount equal to 80 percent of the reasonable charge (less any deductible where applicable). The physician may not charge the beneficiary more than the applicable deductible and 20 percent co-insurance amounts. A physician may become a participating physician. A participating physician is one who voluntarily enters into an agreement with the Secretary to accept assignment on all claims for the forthcoming year. The MEI-adjusted prevailing charges for nonparticipating physicians are 95 percent of that for participating physicians.

(b) *Payment phase-in.*—No provision.

(c) *Establishment of fee schedule.*—No provision. (see (d) below.)

(d) *Treatment of radiologist and anesthesia services.*—OBRA-1987 required the Secretary to develop a fee schedule for payment for radiologist services beginning in 1989. Radiologist services are those performed by or under the supervision of a board certified or board eligible radiologist or for whom radiology services account for at least 50 percent of Part B billings. The law also required the Secretary to develop a relative value guide for payment for anesthesia services beginning in 1989.

(e) *Determination of relative values.*—The Secretary is required to develop a relative value scale and report to Congress on its development by July 1, 1989. In developing the scale the Secretary is required to take into account the recommendations of the PPRC.

(f) *Coding.*—HCFA has required carriers to use a national uniform common procedure coding system known as the HCFA Common Procedure Coding System (HCPCS)

(g) *Establishment of initial conversion factors.*—No provision.

(h) *Changes in conversion factors for subsequent years.*—No provision.

(i) *Geographic adjustments.*—No provision.

(j) *Target rates of increase in expenditures.*—No provision.

(k) *Limitation on beneficiary liability.*—OBRA-1986 placed a limit on actual charges of nonparticipating physicians which is known as the maximum allowable actual charge (MAAC). Nonparticipating physicians whose actual charge for a service in the preceding year equals or exceeds 115 percent of the current year's prevailing charge, may increase their charges by no more than one percent. Nonparticipating physicians whose actual charge for the preceding year is below 115 percent of the current year's prevailing charge may increase their actual charges over a four-year period, 1987-1990, such that in 1990 their MAAC may equal 115 percent of the prevailing charge. If a physician knowingly and willfully bills above his MAAC limit, the Secretary may apply sanctions including barring physicians from participating in Medicare for up to five years and/or imposing a civil monetary penalty or assessment.

(l) *Monitoring.*—No provision.

(m) *Sending information to physicians.*—Carriers are required, at the beginning of each year, to provide nonparticipating physicians with a list of the physician's MACCs for that physician's most commonly furnished services.

(n) *Restrictions on administrative and judicial review.*—Administrative and judicial review may not be made of determinations of prevailing charges for overpriced procedures or cataract surgical procedures.

(o) *Requirements for carriers.*—No provision.

(p) *Bonus payments for services furnished in health manpower shortage areas.*—OBRA-1987 provided for a bonus of 5 percent of the Medicare payment amount for physicians services provided in a rural area which is designated as a class 1 or class 2 health manpower shortage area.

(q) *Studies.*—

(1) *GAO study of alternative payment methodology for malpractice component.*—No provision.

(2) *GAO study examining alternative malpractice resolution systems.*—No provision.

(3) *Study of payments to risk contracting plans.*—Medicare makes payments to a qualified health maintenance organization on the basis of the number of beneficiaries enrolled in the plan. The amount of the monthly capitation payment is based on the adjusted average per capita cost (AAPCC). The AAPCC reflects Medicare expenditures in each locality for services provided by physicians and providers billing on a fee-for-service basis.

(4) *Study of carve-out from target rate of increase in expenditures.*—No provision.

(5) *Study of electronic billing.*—The law authorizes carriers to develop direct lines for electronic receipt of claims from participating physicians.

(6) *Study of target rate of increase in expenditures or study of volume performance standards.*—No provision.

(7) *PPRC study of payment for overhead.*—No provision.

(r) *Conforming changes.*—The law sunsets the MAAC program on the earlier of December 31, 1990 or one year after the date the Secretary reports to Congress on the development of a relative value scale.

OBRA-1986 required development by HCFA of a common procedure coding system and required Part B payments to be made under this system by January 1, 1993.

(s) *Revision of participation periods.*—The participation period under the physician participation program is January 1-December 31 of each year.

(t) *Expedited procedures for initial implementation.*—No provision.

(u) *Role of PPRC.*—PPRC is required to make recommendations to the Secretary concerning development of a relative value scale.

House bill

(A) IN GENERAL

Section 10123.—Amends Title XVIII of the Social Security Act by adding a new Section 1848, "Payment for Physicians' Services Based on a Resource-Based Relative Value Schedule." A new fee schedule is phased-in over the Oct. 1991 - Jan. 1996 period. Beginning October 1, 1991, payments for physicians services are to be based on the lesser of: (1) the actual charge; or (2) the fee schedule amount (as established below.) The fee schedule amount for non-participating physicians is 95% of the amount otherwise determined. The term physicians services includes only those services

provided by doctors of medicine or osteopathy and diagnostic tests and X-ray services (not including clinical diagnostic laboratory tests) furnished in connection with physician services.

Establishes expenditure targets for physicians services beginning in FY1990.

Phases-in new limits on actual charges beginning in 1991 so that the limit would equal 115% of the fee schedule amount in 1993.

Section 4001.—Amends Title XVIII of the Social Security Act by adding a new Section 1848, “Resource Based Relative Value Scale for Physicians Services.” The current reasonable charge methodology is replaced by a fee schedule based on a relative value scale. The fee schedule is phased-in over 4 years beginning April 1, 1990. During 1990 and 1991, adjustments are to be made in current prevailing charges based on differences between prevailing charges and a reference fee schedule; during 1992, payments are made under an adjusted fee schedule. During 1990, the provision only applies to procedures specified by the Congress; beginning in 1991, the provision applies to all physicians services (including diagnostic tests and X-ray services, except clinical diagnostic laboratory tests furnished in connection with physician services.)

Specifies that the reform is to be carried out in a budget neutral fashion in each year of the transition.

Establishes, beginning in 1991, a maximum limit on the amount nonparticipating physicians can charge equal to 120% of the Medicare prevailing charge or fee schedule amount.

(B) PAYMENT PHASE-IN

Section 10123.—Limits reductions and increases to 15% in any year. Specifies that in the case of a service for which the historical payment basis is less than 85% of the fee schedule amount for 1991, the recognized fee schedule amount would be 115% of the historical payment basis in the last three months of 1991 and in 1992. For services furnished in 1993, 1994, or 1995 the recognized fee schedule amount would be 115% of the previous year’s recognized amount; in no case could the recognized fee schedule amount exceed the applicable fee schedule amount.

Specifies that in the case of a service for which the historical payment basis exceeds 115% of the fee schedule amount for 1991, the recognized fee schedule amount would be 85% of the historical payment basis in the last three months of 1991 and in 1992. For services furnished in 1993, 1994, or 1995 the recognized fee schedule amount would be 85% of the previous year’s recognized amount; in no case could the recognized fee schedule amount be less than the fee schedule amount.

Defines the historical payment basis as the weighted average prevailing charge for the service applied in a locality in 1991, adjusted to reflect payments for services with charges below the prevailing charge level. The historical payment basis is determined by the Secretary without regard to physician specialty. For purposes of these calculations, localities are the same as those used for payment purposes on the date of enactment.

Section 4001.—Requires the Secretary, for services provided from April 1990-December 1990, to provide for an adjustment in the pre-

vailing charge otherwise applied equal to $\frac{1}{4}$ of the difference between the reference fee schedule and the prevailing charge otherwise applied for the service. The adjusted prevailing charge will be treated for all subsequent periods as the prevailing charge applied in 1990. Evaluation and management services would all receive the same percentage increase (or decrease) in 1990 based on the weighted average that each such service would otherwise receive under the formula. Evaluation and management services are defined as primary care services (as the term is used under current law) and hospital medical services and consultations.

Requires the Secretary, for services provided in 1991, to provide for an adjustment in the prevailing charge equal to $\frac{1}{4}$ of the difference between the reference fee schedule and the prevailing charge otherwise applied. The prevailing charge level is the 1990 level increased by the 1991 MEI without regard to customary charge levels. The adjusted prevailing charge is to be treated for all subsequent periods as the prevailing charge applied in 1991. Evaluation and management services are treated in the same way as in 1990.

Provides that for 1992 payment is to be based on the lesser of the actual charge or the fee schedule amount. The Secretary is to adjust the fee schedule amount by $\frac{1}{2}$ of the difference between the fee schedule amount and the prevailing charge level. The prevailing charge level is the adjusted 1991 level increased by the 1992 MEI. The Secretary will provide for construction of a proxy prevailing charge in the case of a physician's service which is reclassified or recoded and no prevailing charge exists for 1991. If the fee schedule area changes from 1991 to 1992, the Secretary is required to calculate the prevailing charge based on the weighted average of the prevailing charges that would otherwise have applied in the portions of the old fee schedule area included in the new fee schedule area.

Specifies that beginning in 1993 payments are made on the basis of the fee schedule without any adjustment for prevailing charges. The Secretary is prohibited from requiring carriers to recompute customary charges with respect to services furnished during or after 1992 or prevailing charges for services furnished after 1992.

(C) ESTABLISHMENT OF FEE SCHEDULE

Section 10123.—Requires the Secretary to establish a national fee schedule by October 1, 1991 that sets a payment amount for all physicians' services furnished in all physician payment areas in a year. A payment area is each urban area and the rural area within each State as those areas are defined for payment purposes under the prospective payment system.

Specifies that the fee schedule amount is equal to the sum of the following:

(1) Work Payment Amount: the product of (A) work relative value units for the service, and (B) the work conversion factor for the year for the category of services;

(2) Overhead Payment Amount: the product of (A) the number of overhead relative value units for the service, (B) the overhead conversion value for the year for the category of serv-

ices, and (C) the geographic overhead index value for services furnished in the payment area; and

(3) Malpractice Payment Amount: the product of (A) the number of malpractice relative value units for the service, (B) the malpractice conversion factor for the year for the category of services, and (C) the geographic malpractice index value for services furnished in the same payment area.

Section 4001.—Requires the Secretary to apply, for the period April–December 1990, a reference fee schedule covering each of the physicians services specified in Appendix A of the explanation of the Committee on Energy and Commerce to accompany the House Budget Report on OBRA-1989. This specification is based on available data and recommendations of the PPRC. The reference fee schedule in a fee schedule area represents the product of (1) the relative value for the service, (2) the national standard conversion factor, and (3) the geographic adjustment factor. Fee schedule areas are the same as localities currently used for payment purposes.

Requires the Secretary to establish a reference fee schedule covering each physicians service by October 1, 1990 for application in 1991. The reference fee schedule is the product of the relative value for the service, the national standard conversion factor and the geographic adjustment factor. Fee schedule areas are the same as localities currently used for payment purposes.

Requires the Secretary to establish a fee schedule covering each physicians service by October 1 of each year (beginning in 1991) for use in the following year. The fee schedule amount is the product of the relative value for the service, the national standard conversion factor and the geographic adjustment factor. Beginning in 1992, fee schedule areas are to be comprised of either (1) each State in its entirety, or (2) each metropolitan statistical area (or New England County Metropolitan area or comparable area recognized by the Secretary) and each portion of each State which is outside such area. The Secretary is to report to Congress by July 1, 1991 on which of these approaches should be used.

(D) TREATMENT OF RADIOLOGIST AND ANESTHESIA SERVICES

Section 10123.—Authorizes the Secretary to waive or adjust application of the fee schedule requirement in the case of radiologist services for which payment would otherwise be made under the OBRA-1987 fee schedule provision. A similar waiver or adjustment may be made in the case of anesthesia services for which a relative value guide has been established.

Section 4001.—Establishes a special provision for the establishment of a reference fee schedule in 1991 for anesthesia services for which a relative value guide has been established. Instead of relative values and the national standard conversion factor, the Secretary shall use, to the extent practicable, the relative value guide with appropriate adjustment of the conversion factor. This is to be done in a manner to assure that the reference fee schedule amounts for anesthesia services in fee schedule areas are consistent with reference fee schedule amounts for other services determined by the Secretary to be of comparable value in those areas. The Secretary is to adjust the reference fee schedule amounts by

geographic adjustment factors in the same manner applicable to other services. The Secretary may provide for an overall percentage adjustment for anesthesia services in a manner similar to the overall percentage adjustment provided for evaluation and management services. The provisions relating to anesthesia services are also applicable for 1992 and subsequent years.

Requires the Secretary to base the relative value for radiology services (as defined for purposes of the OBRA-1987 fee schedule) on the relative value scale developed under the fee schedule with appropriate modifications to assure that relative values are consistent with relative values established for similar or related services.

(E) DETERMINATION OF RELATIVE VALUES

(1) Components of physicians services

Section 10123.—Divides physicians services into three components: work component, overhead component, and malpractice component.

Defines “work component” as that portion of the resources used in furnishing the service that reflects physician time and intensity. This portion includes activities before and after patient contact. For surgical procedures the term is to reflect a global definition including pre-and post-operative physicians services.

Defines “overhead component” as that portion of the resources used in furnishing the service that reflects the overhead (as defined by the Secretary) other than overhead associated with malpractice expenses, in furnishing the service.

Defines “malpractice component” as that portion of the resources used in furnishing the service that reflects malpractice expenses.

Section 4001.—Specifies that for 1990 the relative value for a physicians service is the sum of the relative values of the components for practice expenses and for physician work. These components are specified in Appendix A of the explanation of the House Energy and Commerce Committee bill included in the House Budget Committee report on OBRA-1989. The values are based on the relative resources used. Practice expenses are based on the relative expenses of furnishing services including malpractice expenses and items such as office rent, wages of personnel, etc.; physician compensation and other physician fringe benefits are excluded. The physician work component is based on such factors as relative time and effort.

Specifies that for 1991, the relative value for each physicians service is based on the relative resources used for the practice expense component and physician work component as described above. Beginning in 1992, the relative value for each physicians service is based on the sum of three components—general practice expenses, malpractice expenses, and physician work. The general practice expense component is defined the same way as the practice expense component was defined for earlier years, except that malpractice expenses are excluded. The malpractice expense component relates to relative malpractice expenses, based on the risk category of the class of services furnished (or the specialty of physicians providing the service.)

(2) Determination of relative values for components of physicians services

Section 10123.—Provides for a determination of relative value units for each component.

Requires the Secretary to determine a number of work relative value units for the service based on the relative resources used, incorporating physician time and intensity, in furnishing the service.

Specifies that the number of overhead relative value units is equal to the product of the base allowed charges for the service and the overhead percentage for the service.

Specifies that the number of malpractice value units is equal to the product of the base allowed charges for the service and the malpractice percentage for the service.

Defines base allowed charges as the national average allowed charges for the service for services furnished from Jan.-Sept. 1991, estimated by the Secretary using the most recent available data, consistent with practice cost data.

Section 4001.—Requires the Secretary to use the relative values as defined above for 1990. For 1991, the Secretary, using the best available information and taking into account the recommendations of the PPRC, is to determine the relative value for each physicians service based on the relative resources used for the practice expense component and physician work component as described above. The Secretary is to base the computation of the relative values for the practice expense component on the best readily available data, such as survey data. For 1992, the calculation of relative values is to be made in the same manner as for 1991 except that there are now three components for physicians services.

(3) Extrapolation

Section 10123.—Provides that the Secretary may use extrapolation and other techniques to determine the number of relative value units for low volume services and other services for which adequate data are not available. Such techniques may also be used to determine practice costs for specialties for which adequate practice cost data are not available. The Secretary may establish ancillary policies, such as those relating to modifiers and local codes, in order to implement the requirement for establishing relative value units.

Section 4001.—Provides that beginning for 1991, the Secretary may extrapolate relative values for physicians services for which specific data are not available. The extrapolation is to be based on related services for which such values are available. The Secretary is to specifically take into account recommendations of the PPRC and the results of consultations with organizations representing physicians who provide such services.

(4) Adjustments

Section 10123.—Authorizes the Secretary to adjust relative value units from time to time to take into account changes in medical practice, coding changes, or new data on relative value components. The Secretary may adjust relative value units for specific

services or classes of such services based on a determination of excessive growth in volume or intensity or inadequate access.

Section 4001.—Authorizes the Secretary, for 1993 and succeeding years, to provide, from time to time, for the establishment of relative values for physicians services for which values have not previously been established. The Secretary is to take into account recommendations made by the PPRC and the views of appropriate organizations representing physicians and other interested parties.

Authorizes the Secretary, as he deems appropriate, taking into account PPRC recommendations and views of appropriate physician organizations and other interested parties, to annually adjust relative values and geographic adjustment factors. The Secretary may not make such adjustments if they are intended to result in an overall increase or decrease in aggregate physician payments under Part B.

(5) Determination of percentages

Section 10123.—Requires the Secretary for each physicians service or class of services to determine a work percentage, an overhead percentage, and a malpractice percentage as follows:

(A) Requires the Secretary to determine the average percentage of each service or class of services that is performed nationwide under Medicare by physicians in each of the different physician specialties (as identified by the Secretary).

(B) Requires the Secretary to determine the average percentage division of resources among the work component, the overhead component and the malpractice component which are used by physicians in each of the specialties in furnishing physicians services. The percentages are to be based on national data that describe the elements of physician practice costs and revenues by physician specialty.

(C) Specifies that the work percentage for a service is the sum (for all physician specialties) of the average percentage division for the work component for each physician specialty multiplied by the proportion of such service (or services) performed by physicians in that specialty. Similar calculations are made for the overhead percentage and the malpractice percentage.

Specifies that the Secretary may from time to time provide for a recomputation of work percentages, overhead percentages, and malpractice percentages.

Section 4001.—No provision.

(6) No variation for specialties

Section 10123.—Prohibits the Secretary from varying the number of relative value units and conversion factors for the same physicians service either based on whether or not the physician is a specialist or on the type of specialty.

Section 4001.—Specifies that beginning in 1991, the Secretary may not vary the relative values for the same service based on whether the physician furnishing the service is a specialist or type of specialty of the physician.

(f) Coding

Section 10123.—Requires the Secretary to establish a uniform procedure coding system for the coding of all physician services. The Secretary is to provide for an appropriate coding structure, which may incorporate the use of time, for visits and consultations.

Section 4001.—Requires the Secretary to make such changes in the classification and coding of physicians services furnished during or after 1992 as may be required to (1) provide for uniform classification and coding in all fee schedule areas, (2) classify and code related pre- and post-operative physicians services with a surgical procedure, and (3) take into account time in classifying and coding of evaluation and management services. In order to take into account changes in coding and fee schedule areas from 1991 to 1992, the Secretary may require that 1991 bills indicate the 1992 fee schedule areas and the 1992 classification and code.

(g) Establishment of initial conversion factors

Section 10123.—Requires the Secretary by September 1, 1991 to establish and report to the Congress concerning conversion factors to be used for categories of services furnished beginning October 1991. The conversion factors for each component will be established so that the aggregate amount of Part B payments for each component of physicians services furnished from Oct.-Dec. 1991 will be the same as that which would have been made if the section did not apply.

Section 4001.—Requires the Secretary to establish and report to the Congress by February 1, 1990 on the national standard conversion factor to be used for the 9-month period beginning April 1, 1990. The conversion factor is to be established to achieve budget neutrality in 1990. The Secretary is to provide appropriate adjustments to take into account changes in volume and distribution of services according to the instructions contained in Appendix B of the Energy and Commerce portion of the House Budget Committee report on OBRA-1989.

(h) Changes in conversion factors for subsequent years

Section 10123.—(1) Requires the Secretary by February 1 of each year (beginning with 1991) to transmit to the Congress a recommendation on the appropriate change in the conversion factors for categories of physicians services (i.e., surgical services and such other category of services deemed appropriate by the Secretary.) In making the recommendation, the Secretary is required to consider the increase in the appropriate index (i.e., MEI or other update index applied to the same services that such indexes were applied in 1989), the actual increase in expenditures compared to the target rate of increase for the previous fiscal year, changes in volume or access to services, and other factors the Secretary deems appropriate. The Secretary may also recommend changes in the number of relative value units to be applied in the case of physicians services or classes of services for which the Secretary finds there has been an excessive growth in volume or intensity of services or inadequate access. The Secretary, in making recommenda-

tions, is required to consider how the rate of increase in expenditures for the category of services compares to the target rate of increase for such category.

(2) Requires the Physician Payment Review Commission to review the Secretary's recommendation and make its recommendations to Congress by May 1 regarding changes in conversion factors (and any changes in relative value units) for the following year.

(3) Requires the Secretary to publish in the Federal Register during the first 15 days of November each year (beginning with 1991) the conversion factors which will be in effect for the following year for each category of physicians services. Unless the Congress provides otherwise, such factor for a fiscal year for a category of services is the previous years conversion factor for the category modified as follows:

(A) Increased by the Secretary's estimate of the percentage increase in the appropriate index (i.e. MEI or other update index applied to the same services that such indexes were applied in 1989), for the following year;

(B) Increased or decreased by the same percentage by which the percentage increase in actual Part B expenditures for the category of services for the previous fiscal year was less than or greater than the expenditure target for that fiscal year; and

(C) Increased or decreased by such amount as the Secretary determines to be necessary to offset, with respect to total Part B payments, any increase or decrease in relative value units.

Provides that the Secretary may specify in the Federal Register changes to be made in relative value units for specific physicians services or classes of services. These are services for which the Secretary has determined there has been an excessive growth in volume or intensity or for which there is inadequate access.

Section 4001.—Requires the Secretary by October 1, 1990 to establish and report to the Congress on the national standard conversion factor to be used in 1991. The conversion factor is to be established to achieve budget neutrality in 1991. The Secretary, taking into account the recommendations of the PPRC, is to provide appropriate adjustments to take into account projected changes in volume and distribution of services. The Secretary's report must identify and evaluate components of changes and explain the basis for adjustments. The same requirements are applicable for establishment of the 1992 conversion factor.

Requires the Secretary by August 1 of each year (beginning in 1992) to establish and report to the Congress concerning the national standard conversion factor to be used the following year. The factor is the previous year's factor adjusted by the projected percentage change between the midpoint of the two years in an appropriate index. The index is to reflect the value of the resources (including practice expenses, malpractice expenses and physician work effort) used in furnishing physicians services. The Secretary is to establish the index taking into account recommendations of PPRC and views of appropriate organizations.

(I) GEOGRAPHIC ADJUSTMENTS

(1) In general

Section 10123.—Requires the Secretary to establish a geographic overhead index which establishes a numerical relationship between the costs of goods and services composing the overhead component in each physician payment area compared to the national average cost of such goods and services.

Requires the Secretary to establish a geographic malpractice index which establishes a numerical relationship between the costs of professional liability insurance in each physician payment area compared to the national average costs of professional liability insurance.

Section 4001.—Provides for a geographic adjustment factor for each physicians service for each fee schedule area in 1990 and requires the Secretary in subsequent years to establish such factors. Requires the Secretary for 1991, to establish (A) a practice cost index reflecting the relative costs of the mix of goods and services in the different fee schedule areas compared to the national average, and (B) an index reflecting half the difference between the relative value of physicians work effort in each fee schedule area compared to the national average. The Secretary may establish class specific geographic cost of practice indices if the application of a single index would be substantially inequitable. Similar requirements are applicable for 1992, except that the practice cost index is to exclude malpractice expenses. A separate malpractice cost index is to be developed which reflects relative costs of malpractice expenses in the different fee schedule areas compared to the national average.

(2) Calculation of geographic adjustment factor

Section 10123.—No provision.

Section 4001.—Specifies that in 1990 and 1991 the geographic adjustment factor is equal to the sum of the geographic cost-of-practice adjustment factor and the geographic physician work adjustment factor. Beginning in 1992, the geographic adjustment factor is equal to the sum of the geographic cost of practice adjustment factor, the geographic malpractice cost adjustment factor and the geographic physician work adjustment factor.

Specifies that the geographic cost-of-practice adjustment factor for a service for a fee schedule area is the product of:

(A) the ratio of the relative value of the practice expense component of the service to the total relative value for the service; and

(B) the geographic cost-of-practice index value for the area for the service. For 1990, the elements in item (A) are specified in Appendix A of the Energy and Commerce Committee portion of the House Budget Committee report on OBRA-1989. Beginning in 1991, the values are based on the Secretary's calculations. For 1990, the index value for the area for item (B) is based on the relative costs of a mix of goods and services composing practice expenses in the fee schedule for a typical physicians service compared to the national average for such service

as specified in Appendix C of the report. Beginning in 1991, the index value for item (B) is based on the Secretary's calculations.

Specifies that in 1990 and 1991, the geographic physician work adjustment factor is the product of:

(A) 1 minus the ratio of the relative value of the practice expense component of the service to the total relative value for the service (as these items are defined for that year); and

(B) the geographic physician work index value for the area. For 1990, the value in item (B), which is based on half the difference between the relative value of physicians work effort in the fee schedule area and the national average, is specified in Appendix C of the report. Beginning in 1991, the index value for item (B) is based on the Secretary's calculations.

Specifies that beginning in 1992, the geographic physician work adjustment factor is the product of:

(A) 1 minus the sum of the ratios of the relative value of the practice expense component of the service and the relative value of the malpractice expense component for the service to the total relative value for the service; and

(B) the geographic physician work value for the area.

Defines the geographic malpractice adjustment factor as the product of:

(A) the ratio of the relative value of the malpractice expense component for the service to the total relative value for the service, and

(B) the geographic malpractice index value for the area.

(See (e)(4) above for budget neutrality requirement).

(J) TARGET RATES OF INCREASE IN EXPENDITURES

(1) Initial target

Section 10123.—Specifies that for FY 1990, the target rate of increase in expenditures for a category of services is equal to the Secretary's estimate of the current baseline percentage increase reduced by the OBRA-1989 percentage savings, further reduced by ½ percentage point. The current baseline percentage is defined as the Secretary's estimate (based on the law in effect before the enactment of OBRA-1989) of the percentage by which the total actual Part B expenditures for such category of services in FY 1990 will exceed such expenditures in FY 1989. The OBRA-1989 percentage savings is defined as the Secretary's estimate of the percentage by which the current baseline percentage increase for the category of services exceeds the increase which would occur if the estimate were based on the law in effect after enactment of OBRA-1989.

Specifies that the target rates of increase are to be adjusted so as to reflect the differences in the actual proportion of enrollees in HMOs with Medicare risk-sharing contracts in FY 1990 as compared with FY 1989.

Section 4001.—No provision.

(2) Calculation for subsequent years

Section 10123.—Requires the Secretary by February 1 of each year (beginning in 1990) to recommend to Congress the target rate of increase in expenditures for each category of services for the fiscal year beginning the following October. In making the recommendation, the Secretary is required to confer with associations representing the major physician specialties. The Secretary is to consider inflation, changes in number of Part B enrollees (other than HMO enrollees), changes in technology, evidence of unnecessary utilization of services, evidence of lack of access to necessary physicians services, and such other factors as the Secretary considers appropriate.

Requires the Physician Payment Review Commission to review the Secretary's recommendation and make recommendations to the Congress by May 1 respecting the target rates.

Requires the Secretary to publish in the Federal Register in September of each year (beginning in 1990) the target rate of increase for the fiscal year beginning in October. Unless otherwise provided by the Congress, each target rate is equal to the sum of the Secretary's estimate of (A) the percentage increase or decrease in the Consumer Price Index between the midpoint of the previous fiscal year to the midpoint of the fiscal year involved, and (B) the percentage increase or decrease in the average number of Part B enrollees (other than HMO enrollees) over the same time period.

Section 4001.—No provision.

(3) Target categories

Section 10123.—Requires the Secretary to determine a target rate of increase in expenditures separately for the category of surgical services and for the category of other physicians services (or for such other categories of services as the Secretary deems appropriate).

Section 4001.—No provision.

(4) Budget baseline

Section 10123.—Provides that for budget baseline purposes, notwithstanding any other provision of law, the target rate of increase for a category of services is not to be used. Instead, the actual percentage increase in Part B expenditures for the category of services during the fiscal year compared to the previous fiscal year is to be used.

Section 4001.—No provision.

(5) Provision of information

Section 10123.—Requires the Secretary to establish procedures for reporting information, required to be reported by the carriers on a monthly basis, concerning expenditures and volume of physicians services. The information is to be provided monthly to the Physician Payment Review Commission, the Congressional Budget Office, the Congressional Research Service, the House Committees on Ways and Means and Energy, and Commerce and the Senate Committee on Finance.

Section 4001.—No provision.

(6) Services included

Section 10123.—Specifies that services included under the expenditure target includes physicians services and other items and services (such as laboratory tests and X-rays), specified by the Secretary that are commonly performed or furnished by a physician or in a physician's office. The term does not include services furnished to an HMO enrollee under a Medicare risk-sharing contract.

Section 4001.—No provision.

(K) LIMITATION ON BENEFICIARY LIABILITY

(1) Sanctions

Section 10123.—Permits the Secretary to impose sanctions against nonparticipating physicians who knowingly and willfully bill on a repeated basis in excess of the limiting charge for Part B physicians services furnished on or after January 1, 1991. Sanctions which may be imposed are the same as may be imposed for billing above the MAAC limits.

Section 4001.—Similar provision. Applies to billings in excess of actual permitted charge.

(2) Extra billing limit for 1991

Section 10123.—Specifies that for physicians with a MAAC limit at or below 125 percent of the recognized payment amount for nonparticipating physicians in 1990, the limit on actual charges in 1991 is the same percentage above the recognized payment amount as during 1990. For physicians with MAAC limits above 125 percent in 1990, the limit on actual charges in 1991 is 125 percent of the recognized payment amount for nonparticipating physicians.

Section 4001.—Specifies that the actual charge may not exceed 120 percent of the reference payment amount. The reference payment amount is $\frac{1}{4}$ of the difference between the prevailing charge and the applicable reference fee schedule amount.

(3) Extra billing limit for 1992

Section 10123.—Specifies that for physicians with limits on actual charges at or below 120 percent of the recognized payment amount for nonparticipating physicians in 1991, the limit on actual charges in 1992 is the same percentage above the recognized payment amount as during 1991. For physicians with limits on actual charges above 120 percent in 1991, the limit on actual charges in 1992 is 120 percent of the recognized payment amount for nonparticipating physicians.

Section 4001.—Specifies that the actual charge may not exceed 120 percent of the reference payment amount. The reference payment amount is $\frac{1}{2}$ of the difference between the prevailing charge and the fee schedule amount.

(4) Extra billing limit after 1992

Section 10123.—Specifies that the limiting charge is 115 percent of the recognized payment amount for nonparticipating physicians.

Section 4001.—Specifies that the actual charge may not exceed 120 percent of the fee schedule amount.

(L) MONITORING

Section 10123.—Requires the Secretary to monitor the actual charges of nonparticipating physicians for services furnished on or after January 1, 1991 to Part B enrollees. The Secretary is to monitor changes (by specialty, type of service, and geographic area) in the proportion of services provided by participating physicians, the proportion of services paid on assignment, and the amounts charged above recognized payment amounts. The Secretary is required to make an annual report to Congress regarding such changes. The Secretary is required to develop a plan and submit recommendations regarding the plan if he finds that there has been a significant decrease in participation and assignment rates or an increase in the amounts charged above recognized payment amounts. The Physician Payment Review Commission is required to review the Secretary's plan and recommendations and transmit its comments to the Congress.

Section 4001.—Requires the Secretary to monitor the effects of physician payment reform including the effects on volume, access, quality, percentage of participating physicians, percentage of claims paid on assignment, and the amount of balance billing.

(M) SENDING INFORMATION TO PHYSICIANS

Section 10123.—Requires the Secretary to send to each physician furnishing Part B physicians services information on the 1991 fee schedule amount (and whether the phase-in provisions apply) for each of the physicians 30 most frequently furnished services. The information must also include an estimate of the fee schedule amounts that would apply for each of these services in 1992 and 1993 if no reduction were required by virtue of the expenditure targets. Information is to be transmitted in conjunction with notices sent to physicians regarding the participation program. For subsequent years the Secretary is required to provide information on the fee schedule amount for the year and whether the phase-in provisions continue to apply for these services.

Section 4001.—No provision.

(N) RESTRICTIONS ON ADMINISTRATIVE AND JUDICIAL REVIEW

Section 10123.—Specifies that there may be no administrative or judicial review of (1) the determination of the historical payment basis; (2) the determination of relative value units; (3) the determination of conversion factors; (4) the establishment of values in the geographic overhead index and the values in the geographic malpractice index; and (5) the establishment of the system for the coding of physicians services.

Section 4001.—Specifies that there may be no administrative or judicial review of the (1) percentage adjustments in prevailing

charges for evaluation and management services for 1990 and 1991, (2) establishment of relative values and components of relative values, (3) national standard conversion factor, (4) geographic indices and adjustment factors, and (5) selection of fee schedule areas.

(O) REQUIREMENTS FOR CARRIERS

Section 10123.—Requires carriers to report to the Secretary monthly on expenditures and volume of physicians services by category of physicians services and physician specialty within each payment area. Included in the term physicians services are other items and services commonly furnished in physicians offices, excluding services furnished to HMO enrollees under a Medicare risk-sharing contract.

Section 4001.—No provision.

(P) BONUS PAYMENTS FOR SERVICES FURNISHED IN HEALTH
MANPOWER SHORTAGE AREAS

Section 10123.—Limits bonus payments to primary care services.

Section 4001.—No provision.

(Q) STUDIES

(1) *GAO study of alternative payment methodology for malpractice component*

Section 10123.—Requires the GAO to study alternative ways of paying under the new Section 1848 (physician payment reform) for Medicare's share of malpractice expenses. The study must examine paying for the malpractice component using the following approach. Physicians would be required to submit periodic cost reports including detailed information for Medicare and other services on practice expenses, malpractice premiums, and charges imposed and revenues received. Under this approach payment would be paid quarterly or annually based on the proportion of each physicians malpractice premiums that corresponds to the portion of total revenues from Medicare covered services. The GAO is required to submit a report to Congress on the study by April 1, 1991.

Section 4001.—No provision.

(2) *GAO study examining alternative malpractice resolution systems*

Section 10123.—Requires the GAO to study alternative resolution procedures for malpractice claims respecting professional services furnished under Medicare. The examination is to include a review of the feasibility of establishing procedures that involve no-fault payment or that involve mandatory arbitration. GAO is required to submit a report on the study to Congress by April 1, 1991.

Section 4001.—No provision.

(3) *Study of payments to risk contracting plans*

Section 10123.—Requires the Secretary to conduct a study of how payments under the new physician payment reform provision may affect payments to Medicare risk-contracting plans. The Secretary is required to submit a report on this study, including recommen-

dations for changes in the current payment methodology, to Congress by April 1, 1990.

Section 4001.—No provision.

(4) Study of carve-out from target rate of increase in expenditures

Section 10123.—Requires the Secretary to conduct a study on the feasibility and design of a carve-out for managed health care organizations from the expenditure target system. The study is to consider alternative definitions of such organizations and means to assure that such organizations do not underserve their patients or shift care outside of the organization (in order to exceed the target). The Secretary is required to report to Congress by May 1, 1991 on the study. The Secretary is required to include in the report a description of the impact of a carve-out policy on program expenditures and services.

Section 4001.—No provision.

(5) Study of electronic billing

Section 10123.—Requires the Secretary to conduct a study of the feasibility and costs of providing for electronic submission and payment of claims from participating physicians under Part B. The study is to consider (A) the feasibility of making payments on the next business day for clean claims or claims processed entirely by computer, (B) direct deposit of payments, (C) providing participating physicians with (or reimbursing them for) such electronic equipment, software, and technical assistance needed to submit claims electronically. The Secretary is required to report to Congress by January 1, 1991, on the study.

Section 4001.—No provision.

(6) Study of target rate of increase in expenditures or study of volume performance standards

Section 10123.—Requires the Physician Payment Review Commission to study the feasibility of establishing separate expenditure targets by geographic area (region, State, or other area), by specialty or group of specialties, by type of services (such as primary care, services of hospital-based physicians, and other inpatient services), or by combinations of these. PPRC is to include a study of the scope of services included in and excluded from the expenditure target system. PPRC is required to report to Congress by May 1, 1990 together with its recommendations concerning the feasibility of establishing separate target rates.

Section 4001.—No provision.

(7) PPRC study of payment for overhead

Section 10123.—Requires PPRC to conduct a study on how payment for the overhead component for physicians services under the payment reform provision could vary for different procedures (or groups of procedures) and physician payment area. PPRC is required to report on the study together with its recommendations by May 1, 1990, to the House Committees on Ways and Means and Energy and Commerce and the Senate Committee on Commerce.

Section 4001.—No provision.

(R) CONFORMING CHANGES

Section 10123.—Sunsets the MAAC program on December 31, 1990. Conforming changes are made to sections relating to payment for services of certified registered nurse anesthetists, radiologists, nurse midwives, and physicians assistants.

Section 4001.—Delays the date for requiring the Secretary to consolidate codes under the common procedure coding system until January 1, 1993. Makes conforming changes in sections relating to differential for participating physicians, physicians services for persons with end stage renal disease, and payments for services of certified registered nurse anesthetists, radiologists, and nurse midwives. Makes changes in references to MAACs.

Includes, effective January 1, 1990, intermediate and comprehensive office visits for eye examinations and treatments within the definition of primary care services.

(S) REVISION OF PARTICIPATION PERIODS

Section 10123.—Revises participation periods for 1991 and 1992. The first period is January 1, 1991-September 30, 1991; the second period is October 1, 1991-December 31, 1992. The Secretary is required to provide an opportunity to enroll before October 1, 1991 and is required to publish directories of participating physicians at the beginning of the 15-month period beginning on that date.

Section 4001.—Extends the 1989 participation period through March 31, 1990, except in the case of a participating physician who requests that the participation agreement be terminated; this request must be made before December 31, 1989. Physicians may not enroll as participating physicians for the three month period beginning January 1, 1990. The 1990 participation period is 9-months beginning April 1, 1990. The Secretary is required to provide an opportunity to enroll before that date and to publish directories of participating physicians at the beginning of the 9-month period beginning on that date. Specifies that the 1990 MAAC list must be provided to nonparticipating physicians by April 1, 1990.

(T) EXPEDITED PROCEDURES FOR INITIAL IMPLEMENTATION

Section 10121.—No provision.

Section 4001.—Specifies that in order to implement the new requirements for 1990 and 1991 on a timely basis, the Secretary may provide for publication of regulations on an interim, final basis.

(U) ROLE OF PPRC

Section 10123.—No provision. (See item (g) above.)

Section 4001.—Deletes requirement for recommendations concerning a relative value scale. Requires recommendations concerning the new physician payment methodology, specifically including relative values established and adjustments to such values, the national conversion factors to be applied, and the geographic adjustment factors.

Effective date

Section 10123.—Enactment, except: (o) relating to reporting requirements for carriers applies to contracts entered into on or after date of enactment; and (p) limiting bonus payments for services in health manpower shortage areas applies to services furnished on or after the first date which the physician payment reform provisions apply to such services.

Section 4001.—Applies (except as otherwise specifically stated in the section) to physicians services furnished on or after April 1, 1990, except: (k) relating to limits on extra billing applies to services furnished after December 31, 1990, and (u) relating to PPRC's role to reports beginning with the 1990 report.

Senate amendment

No provision.

Conference agreement

(a) *In general.*—The conference agreement includes provisions included in Sections 10123 and 4001 of the House bill as well as provisions included in S. 1750 as reported by the Senate Finance Committee. The conference agreement provides that payments under Medicare are to be made under a fee schedule based on a resource-based relative value scale. The fee schedule is phased-in over the 1992-1996 period.

Volume performance standards are established by Congress for physicians' services beginning in 1990.

The new limits on actual charges are phased-in beginning in 1991 so that the limit would equal 115 percent of the fee schedule amount in 1993 and thereafter.

(b) *Payment phase-in.*—Includes portions of both House provisions with modifications. In the case of a service for which the historical payment basis is less than 85 percent of the fee schedule amount for 1992, the recognized basis of payment would be 115 percent of the historical payment basis in 1991 increased by the 1992 update and further increased by 15 percent of the fee schedule amount.

In the case of a service for which the historical payment basis exceeds 115 percent of the fee schedule amount for 1991, the recognized payment basis would be the historical payment basis in 1991 increased by the 1992 update and decreased by 15 percent of the fee schedule amount.

The historical payment basis is defined as the weighted average prevailing charge for the service applied in a locality in 1991, adjusted to reflect payments for services with charges below the prevailing charge level. The historical payment basis is determined by the Secretary without regard to physician specialty.

For the period 1993-1995, the remaining difference each year between the recognized payment amounts and the fee schedule amount is reduced by $\frac{1}{4}$ in 1993, $\frac{1}{3}$ in 1994 and $\frac{1}{2}$ in 1995. Beginning in 1996, all payments are made on the basis of the fee schedule.

(c) *Establishment of fee schedule.*—The conference agreement includes the House provision with an amendment. The Secretary is

required by January 1 of each year (beginning in 1992) to provide for a national fee schedule for payment of physicians services in all localities. Payment under the fee schedule is equal to the product of the conversion factor for the year for all physicians services (or for each category of services) and a relative value for each service. A category of physicians services means surgical services, and all physicians services other than surgical services and such other category or categories as the Secretary from time to time defines in regulations. The Secretary is also required to publish a model fee schedule by September 1, 1990.

(d) Treatment of radiologist and anesthesia services.—The conference agreement includes Section 4001 with an amendment. The Secretary is required to base the relative values for radiology services (including radiology services paid under the current fee schedule) on the relative value scale developed for the current fee schedule. The Secretary is to make appropriate modifications to the relative values to assure that the relative values established for radiology services which are similar or related to other physicians services are consistent with the relative values established for comparative services. The conferees intend that aggregate expenditures for services for which the adjustment is made are budget neutral compared to expenditures which would otherwise be made for such services if payment were determined under the resource-based relative value scale.

The conference agreement provides that the Secretary, to the extent practicable, is to use the relative guide developed for anesthesia services pursuant to OBRA '87. The Secretary is to make appropriate adjustment to the conversion factor so as to assure that the fee schedule amounts for anesthesia services are consistent with the fee schedule amounts for other services determined by the Secretary to be of comparable value.

The Secretary, in making these adjustments, is required to consult with PPRC and organizations representing physicians or suppliers who furnish radiology and anesthesia services.

The Secretary is required to provide for a transition for these services similar to the transition provided for other services.

(e) Determination of relative values.—

(1) Components of physicians services.—The conference agreement includes Section 10123 except that the term “practice expense component” replaces “overhead component.”

(2) Determination of relative values for components of physicians services.—The conference agreement includes Section 10123 with an amendment. In developing relative value units, the Secretary is required to develop a methodology to add work, practice expense and malpractice relative values in such a manner that they produce a single relative value for each service in each locality.

(3) Extrapolation.—The conference agreement includes Section 10123 with technical changes.

(4) Adjustments.—The conference agreement includes the House provisions with a modification. The Secretary is required to provide for adjustments, at least every 5 years, of the relative value units to take into account changes in medical practice, coding changes, new data on relative value compo-

nents, or the addition of new procedures. Adjustments in any year cannot change expenditures by more than \$20 million from what they would otherwise have been. The Secretary is required, in making adjustments, to consult with the PPRC and physician organizations and to publish his methodology for making such adjustments.

(5) *Determination of percentage.*—The conference agreement includes the House provision.

(6) *No variation for specialities.*—The conference agreement includes Section 10123.

(f) *Coding.*—The conference agreement includes Section 10123 with an amendment. After January 1, 1993, the Secretary may incorporate the use of time for visits and consultations. This is 18 months after the due date for the study required on this issue. (See study requirements.) In establishing the coding system, the Secretary is required to consult with the PPRC and other organizations representing physicians.

(g) *Establishment of initial conversion factors.*—The conference agreement includes the House provision with an amendment. The Congress is to establish a conversion factor for each year, beginning in 1992. The conversion factor for each year after 1992 is the conversion factor established for the preceding year adjusted by the update for the year involved. For 1992 only, the initial conversion factor is a conversion factor (determined by the Secretary) which if the provision had applied during 1991 would result in budget neutrality for that year. The Secretary is to publish, during the last 15 days of October 1991, the conversion factor (or factors) which will apply in 1992 and the updates determined for 1992. During the last 15 days of each subsequent year, the Secretary is required to publish the update of updates.

In the absence of Congressional action the default update for all physicians services is set at the Secretary's estimate of the percentage increase in the appropriate update index (the MEI or other appropriate index) plus or minus the performance adjustment. The maximum negative performance adjustment is 2 percent in 1992 and 1993; 3.5 percent in 1994 and 3 percent in 1995 and thereafter. The Secretary is required to publish a default update in November if the Congress has not established a factor by that date.

(h) *Changes in conversion factors for subsequent years.*—The conference agreement includes Section 10123, with an amendment, (See also (g) above). The Secretary's recommendation is transmitted by April 15. The recommendation must be based on actual performance compared to the performance standards. The performance standards are the second preceding year's expenditures increased by the weighted average increase in physician fees, the increase in the population, the 5-year historic change in the volume and intensity of services, and changes resulting from statutory and regulatory changes. The recommendation is also required to include an explicit calculation and reporting of conversion factors which would achieve budget neutrality.

The conference agreement requires the Secretary to transmit to Congress by April 15 of each year (beginning in 1991) a recommendation for the update in the conversion factor (or factors) for all physicians services, and for each category of physician services for

the following year. In making the recommendation, the Secretary is required to consider the increase in the actual increase in expenditures, such increase compared to the volume performance standard for the previous fiscal year, changes in volume or intensity of services, access to services, and other factors the Secretary deems appropriate. The Secretary is authorized to recommend either a single update or differential updates (category of physician services, by procedures or groups of procedures) to the conversion factor or factors.

The Secretary in making recommendations may also consider unexpected changes by physicians in response to the fee schedule, unexpected changes in outlay projections, changes in beneficiary access, changes in quality or appropriateness of care, and any other relevant factors not measured in the resource-based payment methodology.

For 1992, the Secretary is to make a separate determination of the percentage increase in actual expenditures and the relationship of such percentage to the volume performance standard.

The Secretary is required to report (as part of his recommendation to Congress) (1) the update amount for each category of physicians services and for the categories of nonsurgical services, visits, consultations and emergency room services; (2) the rationale for the application of the update to each such category (regardless of whether or not the updates differ); and the data underlying the update recommendations.

(i) Geographic adjustments.—The conference agreement includes both House provisions with an amendment to specify that the physician work index reflects one-fourth of the difference between the relative value of physicians work effort in each fee schedule area compared to the national average. The conferees intend that the Secretary apply the general overhead index to the malpractice component until a separate malpractice index is developed.

(j) Target rates of increase in expenditures or volume performance standards.—The conference agreement provides for establishment of volume performance standards for fiscal years beginning with FY 1990. The standard is to be established by the Congress.

If the Congress fails to act, the Secretary is required to establish an overall standard as well as a standard for surgery and a standard for other services as specified below. The identical methodology would be used to establish each standard.

Under the default, the volume performance standard for fiscal years after 1990 is the sum of (1) the estimated percentage change in physician fees, (2) the estimated change in the number of Part B enrollees (other than HMO enrollees), and (3) a budget neutral historic volume and intensity factor, (4) plus or minus any statutory changes or costs, and (5) minus the performance standard factor. The budget neutral historic volume and intensity factor is the historic volume increase, expressed as a percentage over the previous five year period. The performance standard factor is .5% in 1990, 1.0% in 1991, 1.5% in 1992, and 2.0% thereafter.

The Secretary is required to establish procedures for reporting information, required to be reported by the carriers on a monthly basis, concerning performance standard compliance (including expenditures and service volume by procedure, by category of service

and by specialty within payment areas). The information is to be provided monthly to the Physician Payment Review Commission, the Congressional Budget Office, the Congressional Research Service, the House Committees on Ways and Means and Energy and Commerce and the Senate Committee on Finance.

(k) *Limitation on beneficiary liability.*—The conference agreement follows Section 10123. Further, assignment is mandated for all claims submitted for beneficiaries for whom Medicaid is required to pay Medicare cost-sharing charges.

Physicians, suppliers, and other persons (including employers or facilities to whom Part B payments are made) are required to submit all claims on behalf of beneficiaries on a standard claim form within 1 year of providing the service. The requirement applies to services rendered after September 1, 1990. If assigned claims are not submitted in accordance with the time requirement, payment is to be reduced by 10%. If nonassigned claims are not submitted in accordance with this requirement the Secretary shall impose sanctions.

The agreement further requires the Secretary to encourage and develop a system providing for expedited payment for claims submitted electronically. The Secretary is also encouraged to provide incentives allowing for direct deposit as payments for participating physicians. The Secretary is to provide physicians with necessary technical information to enable them to submit claims electronically. The Secretary is required to submit a plan to Congress on this provision by May 1, 1990.

(1) *Monitoring.*—The conference agreement follows Section 10123 for services furnished after January 1, 1990. Further, the Secretary is required to monitor (1) changes in the utilization of and access to Part B services within geographic, population, and service related categories, (2) possible sources of inappropriate utilization of Part B services which contribute to the overall level of Part B expenditures, and (3) factors underlying these changes and their interrelationships. The Secretary is required to report annually to Congress on changes under (1) above including an examination of factors listed in (3) which may contribute to the changes. The Secretary is to analyze the following factors which may contribute to the changes: utilization of Part B services by State, utilization of services in health manpower shortage areas, visits, surgical procedures, non-surgical procedures, emergency services, mental health services, specific frequently performed services, specific services for which medical practice guidelines are available, appropriateness of services delivered, and other categories or specific services the Secretary determines appropriate.

The Secretary is required to include in his annual report recommendations concerning any identified patterns of inappropriate utilization, utilization review, physician or patient education, problems of beneficiary access to care made evident by the monitoring process, and other factors deemed appropriate.

(m) *Sending information to physicians.*—The conference agreement includes the House provision with modifications.

(n) *Restrictions on administrative and judicial review.*—The conference agreement includes Section 10123 with amendments.

(o) *Requirements for carriers.*—The conference agreement includes the House provision with an amendment to require carriers to monitor and profile physicians billing patterns within each payment area and provide comparative data to physicians whose utilization patterns vary significantly from other physicians in the same payment.

(p) *Bonus payments for services furnished in health manpower shortage areas.*—The conference agreement includes the House provision with an amendment to provide a bonus of 10% of the payment amount for physicians services provided in all health manpower shortage areas.

(q) *Studies.*—(i) GAO Study of Alternative Payment Methodology for Malpractice Component.—The conference agreement includes the House provision.

(ii) GAO Study Examining Alternative Malpractice Resolution Systems.—The conference agreement includes the House provision.

(iii) Study of Payments to Risk Contracting Plans.—The conference agreement includes the House provision.

(iv) Study of Carve-Out From Target Rate of Increase in Expenditures.—No provision.

(v) Study of Electronic Billing.—The conference agreement includes the House provision.

(vi) Study of Target Rate of Increase in Expenditures or Study of Volume Performance Standards.—The conference agreement requires the Secretary to study the feasibility of establishing separate volume performance standards by geographic area (region, State, or other area), by specialty or group of specialties, by type of services (such as primary care, services of hospital-based physicians, and other inpatient services), or by combinations of these. The conferees intend that the report on the study of performance standard rates of increase include information on the need to adjust local performance standard for referral patterns and border crossings, whether each area should have its standard adjusted for prior utilization, whether the definition of services within the performance standard should be modified, and whether HCFA will be able to track expenditures by detailed areas, specialty and type of service.

(vii) PPRC Study of Payment for Overhead.—The conference agreement includes the House provision, with an amendment to require the PPRC to conduct a study of practice expense items.

The conference agreement also requires the Secretary to report to Congress on the standards a qualified physician group must meet to be eligible for an annual election of a separate group performance standard.

The conference agreement requires PhysPRC to study the feasibility and desirability of using MSAs or other payment areas for purposes of Part B payment. PhysPRC is to submit the report to Congress by July 1, 1991. The report is to include recommendations on the desirability and feasibility of retaining current carrier-wide localities, changing to a system of statewide localities, or adopting MSAs or other payment areas for purposes of Part B payment.

The conference agreement also requires the Secretary to conduct a study of the desirability of including time as a factor in establishing visit codes. The Secretary is required to consult with PPRC and submit a report by July 1, 1991. The report is to include recommen-

dations on the desirability of modifying the number of visit codes, whether greater coding uniformity would result from including time in visit codes as compared with clarifying clinical descriptions of existing codes, and ability to audit physician time accurately.

The conference agreement also requires GAO to conduct a study of the effect of anti-trust laws on the ability of physicians to act in groups to educate and discipline peers of physicians in order to reduce and eliminate ineffective practice patterns and inappropriate utilization. The study is to further address anti-trust issues as they relate to the adoption of practice guidelines by third-party payers and the role that practice guidelines might play as a defense in malpractice cases. The report, together with recommendations is to be submitted by July 1, 1991.

The conference agreement also requires the PPRC to undertake a study of the implications of a resource-based relative value scale for physicians services for non-physician practitioners such as physician assistants, clinical psychologists, nurse midwives, and other health practitioners who bill on a fee-for-service basis under Part B.

(r) *Conforming changes.*—The conference agreement includes the House provision with an amendment to sunset the MAAC program on December 31, 1991. The requirements for sending MAAC information are sunsetted effective for services furnished on or after January 1, 1992.

(s) *Revision of participation periods.*—The conference agreement includes no provision.

(t) *Expedited procedures for initial implementation.*—The conference agreement includes no provision.

(u) *Role of PPRC.*—The conference agreement includes no provision.

2. *Reductions in payments for identified overpriced procedures*

Section 10121 of House bill and section 5202 of Senate amendment

Present law

(a) *Reduction in payments for identified overpriced procedures.*—OBRA 87 reduced prevailing charges for selected overpriced procedures for a nine month period beginning April 1, 1988. The procedures, which had been identified by the Physician Payment Review Commission as overpriced included: coronary artery bypass surgery; transurethral prostatectomy; suprapubic prostatectomy; diagnostic and or therapeutic dilation and curettage; carpal tunnel neurolysis and/or transposition; pacemaker surgery; bronchoscopy; upper gastrointestinal endoscopy; knee arthroscopy; and knee arthroplasty. The prevailing charges were reduced by 2 percent, and then were further reduced by a sliding scale amount between 0 and 15% that is determined by a comparison of the local prevailing charge with the weighted national average prevailing charge. Prevailing charges exceeding 150% of the national average were reduced by 15%, while prevailing charges less than 85% of the national average were not reduced by the sliding scale. Prevailing charges between 85% and 150% of the national average were re-

duced by three-thirteenths of one percent for each percent of the prevailing charge exceeding 85% of the national average. In the year following the reduction, the maximum paid to nonparticipating physicians is the sum of their reduced prevailings plus one-half of the difference between physicians' actual charges and the allowed prevailing charge. Judicial or administrative review of the Secretary's determinations of prevailing charge floors was prohibited.

(b) Limits on actual charges of nonparticipating physicians.—In 1988, actual charges for overpriced procedures provided by nonparticipating physicians are limited to halfway between 125 percent of the reduced prevailing charge and the previous year's limit on actual charges. Beginning in 1989, the limit is 125% of the reduced prevailing charge.

House bill

(a) Reduction in payments for identified overpriced procedures.—Makes reductions of up to 15% in the prevailing charges of overpriced procedures for a nine month period beginning April 1, 1990. The list of procedures, which is more extensive than the overpriced procedures identified in OBRA 87, is found in Appendix A of the Ways and Means Committee portion of the House Budget Committee report on OBRA-1989. These are procedures which have been identified as being at least 15% overpriced based on a comparison of what payments would be under a resource based relative value scale and national average prevailing charges.

For overpriced procedures, the amount of the reduction would equal one-half the difference between the 1989 prevailing charge and the locally adjusted reduced prevailing amount up to a maximum of 15 percent. The locally adjusted reduced prevailing amount is defined as the reduced national weighted average prevailing charges multiplied by an adjustment factor. Reduced national weighted average prevailing charges are defined as 1989 national weighted average prevailing charges reduced by the percentage identified in Appendix A. The Secretary is directed to determine the national average weighted prevailing charges using the best data available. The adjustment factor for a locality is defined as .54 plus .46 multiplied by the geographic practice cost index contained in Appendix A.

(b) Limits on actual charges of nonparticipating physicians.—Limits actual charges of nonparticipating physicians to halfway between 125 percent of reduced prevailing charges plus one-half of the difference between their reduced prevailing charges and their actual charges in 1990. In 1991, the special limit is 125 percent of the reduced prevailing charge.

Effective date.—Effective for services rendered on or after April 1, 1990.

Senate amendment

(a) Reduction in payments for identified overpriced procedures.—Similar provision, except that the amount of the reduction for overpriced procedures would equal one-fourth of the difference between the 1989 prevailing charge and the locally adjusted reduced prevailing amount up to a maximum of 15 percent.

*(b) Limits on actual charges of nonparticipating physicians.—*Identical provision.

*Effective date.—*Enactment.

Conference agreement

*(a) Reduction in payments for identified overvalued procedures.—*The conference agreement includes the House provision with an amendment. The amount of the reduction equals one-third of the difference between the 1989 prevailing charge and the locally adjusted reduced prevailing charge amount up to a maximum of 15 percent. The list of overvalued procedures appears in Table 2 in the Joint Explanatory Statement of the Committee of Conference. The list of procedures are those which have been identified as overvalued by at least 10 percent.

The adjustment factor is defined as the sum of the practice expense ratio for the service (specified in Table 1 in the Joint Explanatory Statement) multiplied by the geographic practice cost index value for the locality and 1 minus the practice expense ratio. The geographic practice cost index value is specified for each locality in Table 3 of the Joint Explanatory Statement.

*(b) Limits on actual charges of nonparticipating physicians.—*The conference agreement includes the House provision.

3. Payments for Radiology, Anesthesiology and Pathology Services

Section 10121 and sections 4003, 4004(a) and 4005 of House bill and sections 5203 and 5204 of Senate amendment

Present law

*(a) Payments for radiology services.—*OBRA 87 established a fee schedule for radiology services provided by board certified radiologists and for physicians for whom radiology services constitute half of their Medicare billings. The fee schedule is based on a relative value scale, which assigns a relative value to each procedure. The relative value scale is then converted into a fee schedule using a dollar conversion factor developed by each carrier. The fee schedule was to be implemented on January 1, 1989, but was not implemented until April 1, 1989. Reimbursement for 1989 was limited to 97 percent of the amount allowed by the fee schedule. Updates for succeeding years are based on the previous year's fee schedule, updated by the Medicare Economic Index.

Limits were placed on the amount that nonparticipating physicians subject to the fee schedule are permitted to charge. For 1989, the limit is 125% of the fee schedule amount. The limit is slated to be 120% in 1990, and 115% after 1990.

Carrier instructions permitted an exception for split billing for cardiovascular and interventional radiologists in 1989.

*(b) Payments for anesthesiology services.—*Currently, reasonable charges for anesthesiology services are based on relative value units (RVUs). RVUs measure the complexity and duration of effort required to provide anesthesiology services to a patient. The number of RVUs is summed and multiplied by a conversion factor to determine the reasonable charge. There are three types of RVUs: base units; time units; and modifier units. Each surgical

procedure is assigned a number of base units; the more complex the procedure, the higher the number of base units. Time units are determined from the length of the procedure. Typically, one time unit is recognized for each fifteen minutes the surgery lasts, if anesthesia is provided by an anesthesiologist. If it is provided by a certified registered nurse anesthetist (CRNA), one time unit is allowed for every 30 minutes the surgery lasts. Modifier units can be used to take into account special complications such as the age or physical condition of the patient. Approximately sixty-five percent of carriers recognize modifier units.

The reasonable charge for anesthesiology services is the lowest of the actual charge; the allowed relative value units multiplied by the physician's customary conversion factor; or the allowed relative value units multiplied by the prevailing conversion factor in the locality.

OBRA 87 reduced the base units (other than for specified procedures) recognized in determining the reasonable charge by 10 percent for 2 concurrent procedures, 25 percent for 3 concurrent procedures and 40 percent for 4 concurrent procedures. If more than 4 procedures are supervised concurrently, the physician may bill only for pre-anesthesia services personally furnished to the patient.

OBRA 87 also directed the Secretary to establish a regulation for a uniform relative value guide to be used in all carrier localities after January 1, 1989. HCFA published a proposed rule in January, 1989 that would use the 1988 American Society of Anesthesiologists' 1988 Relative Value Guide as the uniform guide. These rules have not been finally adopted yet.

(c) *Payment for pathology services.*—OBRA 87 required the Secretary to develop a fee schedule for payment of pathology services. The fee schedule is to be derived from a relative value scale (RVS) and conversion factors, and may be applied on a regional, State-wide or carrier service area basis. The Secretary is also to develop an index to adjust the fee schedule after 1990. In developing the fee schedule, the Secretary is required to consult with the Physician Payment Review Commission, the American College of Pathologists and other appropriate physician organizations. The Secretary is required to consider geographic variations in the costs of providing pathology services. No date is specified for implementing the fee schedule, but the Secretary was required to report to the appropriate Congressional committees on the development of the fee schedule by April 1, 1989. That report, which is to include recommendations for protecting beneficiaries against excess balance billings by pathologists, has not been submitted yet.

House Bill

(a) Payments for radiology services

(1) *Conversion factor.*—Section 10121(b). Eliminates the MEI adjustment to the fee schedule for services provided on or after March 31, 1990. Defines a new conversion factor, a locally-adjusted conversion factor, as 92 percent of the national weighted average conversion factor for services furnished in 1989 multiplied by an adjustment factor. The adjustment factor is identical to the one used in making adjustments to overpriced procedures, which is de-

fined as .54 plus .46 multiplied by a geographic practice cost index for the locality.

Specifies that if the base conversion factor in 1989 in a locality exceeds the locally-adjusted conversion factor, the base conversion factor is to be reduced to the locally-adjusted conversion factor, except that the reduction cannot exceed 15 percent of the base conversion factor. Exempts portable x-ray services from any reduction attributed to locally-adjusted conversion factors.

Section 4003.—Specifies that the 1990 conversion factor used in a locality is the average of the 1989 conversion factor and a national average conversion factor adjusted for each locality by a geographic adjustment factor. For subsequent years, the Secretary is to establish a national average conversion factor, which is to be applied to a fee schedule area as adjusted by applicable geographic adjustment factors. The geographic adjustment factors are the same as those applied to physicians' services under the physician payment reform provisions of this bill.

(2) *Reasonable charge limits.*—*Section 10121.*—Establishes a limit on reasonable charges for radiology services not subject to the fee schedule for the 9 month period beginning April 1, 1990. For these services, prevailing charges may not exceed the amount that would have been paid under the fee schedule. Imposes a special limit on actual charges for services provided by nonparticipating physicians. The limit specifies that actual charges for services can not exceed 125% of the reduced reasonable charge plus one half the difference between the previous year's maximum allowable actual charge and the reduced reasonable charge. In the second year, the limit is 125 percent of the reduced prevailing charge.

Section 4003.—No provision.

(3) *X-ray services.*—*Section 10121.*—Directs the Secretary to conduct a study of the costs of furnishing and the payments for portable x-ray services under Part B. The Secretary is to report his findings to Congress not later than one year after enactment, along with a recommendation as to whether these services should be paid for according to the radiology fee schedule or on the basis of a separate fee schedule.

Section 4003.—No provision.

(4) *Nuclear physicians.*—*Section 10121.*—No provision.

Section 4003.—Exempts from services subject to the fee schedule in 1990, services performed by, or under the direct supervision of physicians who are certified, or eligible to be certified, by the American Board of Nuclear Medicine or by the American Board of Radiology (with special competence in Nuclear Radiology).

(5) *Interventional radiologists.*—*Section 10121.*—No provision.

Section 4004.—No provision.

(b) *Payments for anesthesiology services*

Section 10121.—Includes OBRA 87 provision in Title XVIII. Directs the Secretary to establish a relative value guide for use in all localities in reimbursing physicians for anesthesia services. The Secretary is to establish this guide by regulation, and is directed to consult with physician groups in developing the regulation. Expenditures paid under the guide may not exceed expenditures that would have been paid otherwise. Specifies that the Secretary is not

required to establish a relative value guide different from that established pursuant to OBRA 87.

Specifies that time units calculated under the relative value guide are to be counted based on actual time and not rounded up to full time units. Calculation of time units applies both to anesthesia services furnished by both physicians and certified registered nurse anesthetists.

Section 4004.—Specifies that time units used in computing the relative value unit are to be based on actual time (using fractional units) rather than rounding up to full time units. Calculation of time units applies both to anesthesia services furnished by both physicians and certified registered nurse anesthetists.

(c) Payment for pathology services

Section 4005.—Requires the Secretary to implement a fee schedule for pathology services using the relative value scale and conversion factors developed under the OBRA-87 provision. Requires that a geographic adjustment be incorporated in the conversion factor in a manner comparable to that applied under physician payment reform and that the geographic adjustment factor be the same as the one applied under the physician payment reform provisions of this bill.

Effective date.—*Section 10121.*—Effective for services furnished on or after April 1, 1990. Sections 4003, 4004(a) and 4005—Effective for services furnished on or after January 1, 1990.

Senate amendment

(a) Payments for radiology services

(1) Conversion factor.—Eliminates the MEI adjustment to the fee schedule for the first three months of 1990. For the balance of 1990, specifies that the payment amount permitted under the fee schedule equals 95 percent of the amount permitted during 1989.

(2) Reasonable charge limits.—Similar provision, except that prevailing charges can not exceed 98 percent of the prevailing charge levels for services provided during 1989.

(3) X-ray services.—Eliminates the MEI adjustment for the first three months of 1990. Limits payments under the fee schedule for the balance of 1990 to 97 percent of the amount permitted under the fee schedule during 1989.

(4) Nuclear physicians.—Similar provision to Section 4003, except that the exemption from the fee schedule begins on April 1, 1990. Directs the Secretary to make necessary adjustments in the fee schedule to assure that the exclusion of these physicians does not result in either increases or decreases in the amount that would have been paid under the fee schedule in 1990 for radiologist services, including services excluded under this provision.

(5) Interventional radiologists.—Specifies that the exception, issued under carrier instructions, which permitted split billing for cardiovascular and interventional radiologists in 1989 continues for 1990.

(b) Payments for anesthesiology services

Identical provision to Section 10121 regarding calculation of time units under the relative value guide, i.e., that they are to be counted based on actual time and not rounded up to full time units.

(c) Payment for pathology services

No provision.

Effective date.—Enactment.

(a) Payments for radiology services.—(i) *Conversion Factor.*—The conference agreement includes the Senate amendment, with amendments. It eliminates the MEI adjustment to the fee schedule for the first three months of 1990. For the balance of 1990, it specifies that the conversion factors used to determine fee schedule payments equal 96 percent of the conversion factors that applied as of December 31, 1989.

(ii) *Reasonable Charge Limits.*—The conference agreement included no provision.

(iii) *X-Ray Services.*—The conference agreement includes the Senate amendment with an amendment. It specifies that, for portable X-ray services, for the first 3 months of 1990, the fee schedule adjustment is eliminated and that for the balance of 1990, the conversion factors used to determine payment amounts are 100 percent of the conversion factors that applied as of December 31, 1989.

(iv) *Nuclear Physicians.*—The conference agreement includes the Senate amendment, with an amendment. It specifies that, for nuclear medicine services furnished by a physician for whom nuclear medicine services account for at least 80 percent of the physician's Medicare billings, an alternate payment method is applied, beginning after April 1, 1990. In 1990, the alternate payment method is based on one third of the fee schedule applied to radiology services and two thirds on 101 percent of the 1988 prevailing charge for such services. In 1991, the alternate payment amount is based on two thirds of the fee schedule amount applied to radiology services and one third on 101 percent of the 1988 prevailing charge for such services.

(v) *International Radiologists.*—The conference agreement includes the Senate amendment.

The conference agreement also includes the requirement that the Secretary conduct a study of portable X-ray services under Medicare Part B.

The provisions regarding radiology services apply upon enactment.

(b) Payments for anesthesiology services.—The conference agreement includes the House provision contained in Section 10121. In codifying the provision in the 1987 Omnibus Reconciliation Act requiring the Secretary to establish a relative value guide, the conferees do not intend for the Secretary to establish a new relative value guide different from the one established pursuant under that provision. The provision applies to services furnished on or after April 1, 1990.

(c) Payment for pathology services.—The conference agreement included no provision.

4. Medicare Economic Index for 1990

Section 10122 and section 4002 of House bill and section 5201 of Senate amendment

Present law

Under current law, physicians are reimbursed on the basis of reasonable charges, which are defined as the lowest of a physician's actual charge for a service, the physician's customary charge or the prevailing charge for the service in the community. Annual increases in prevailing charges are limited by the Medicare Economic Index (MEI), which reflects yearly increases in overhead costs for physicians and general changes in earnings levels. The MEI serves as a limit on cumulative changes in prevailing charges since 1973. In the absence of Congressional action, the Secretary is authorized to establish the MEI. In OBRA 87, Congress established the increase in the MEI for 1989 at 3 percent for primary care services and 1 percent for other services.

House bill

Section 10122.—Delays the 1990 update for all reasonable charge fee screens, fee schedules, and maximum allowable actual charges for three months until April 1, 1990. Specifies that payment for services performed between January 1, 1990 and March 31, 1990 is to be determined on the same basis as in 1989. The delay applies to all services paid on a reasonable charge or fee schedule basis and subject to an MEI update, except for ambulance services.

Makes conforming changes to participation agreements. Stipulates that 1989 participating provider agreements will remain in effect through March, 1990 unless a physician requests that the agreement be terminated before December 31, 1989. Physicians are to be given an opportunity to become participating providers for 1990 before April, 1990. At the beginning of the 9 month period beginning April 1, 1990, the Secretary is to publish participating physician directories and provide nonparticipating physicians with lists of maximum allowable actual charges.

Specifies that the 1990 MEI increase will be 0 percent for radiology services, anesthesiology services and for other services specified in Appendix A (overpriced procedures); 2 percent for other services and the full MEI adjustment for primary care services.

Section 4002.— Specifies that the MEI adjustment for 1990 is 0 percent.

Effective date.—Section 10122—Enactment. Section 4002—Enactment.

Senate amendment

Similar provision to Section 10122 except that the zero percent MEI adjustment from April 1, 1990 to the end of 1990 applies only to radiology services. Primary care services will receive the full MEI increase, and all other services, other than primary care services, will receive a 2 percent increase.

Effective date.—Enactment.

Conference agreement

The conference agreement continues, for all Part B services, the reductions in payment imposed under the sequester order of October 16, 1989, pursuant to the Balanced Budget and Emergency Deficit Control Act of 1985 (Gramm-Rudman-Hollings). For all Part B services, the reductions continue through March 31, 1990.

The conference agreement includes the House provisions contained in Section 10122 with amendments. It specifies that the exclusion from the delay in the MEI update also applies to clinical laboratory services and clarifies language regarding fee schedule payments subject to the MEI delay.

5. Miscellaneous Provisions Relating to Payments for Physicians Services

Sections 10124 and 4006 of House bill.

Present law

(a) *Customary charge for new physicians.*—OBRA 1987 specified that the customary charge screens for new physicians (who have not been in practice long enough to have sufficient actual charge data) are to be set at level no higher than 80 percent of the prevailing charge for the service. The provision does not apply to primary care services and services furnished in rural health manpower shortage areas.

(b) *Limitation on amounts for certain services furnished by more than one specialty.*—Calculations of prevailing charges take into account existing patterns of charges by different physician specialties. Many carriers have different prevailing charges for the same service when performed by different specialties.

(c) *Waiver of liability limiting recoupment in certain cases.*—In the mid-1980s, HCFA required carriers to use a national uniform system of coding known as the HCFA Common Procedure Coding System (HCPCS). Previously, carriers had used a variety of coding systems. The conversion caused a problem in a few areas. The Texas carrier responded by implementing statewide fees; HCFA concluded that was incorrect and that overpayments had been made.

Section 1870(c) limits recoveries of overpayments in certain cases where individuals are without fault.

House bill

(a) *Customary charge for new physicians.*—

Section 10124.—Provides for a phase-in to the prevailing charge level. For the physicians' first year, current law provisions apply. For the second year, i.e., the first year the provision is in effect, the Secretary is to set the customary charge at a level no higher than 85 percent of the prevailing charge level. The percentage is to be increased to 90 percent in the second year the provision is in effect and 95 percent in the third year the provision is in effect. The provision does not apply to services on or after the date the new physician payment reform provisions apply to such services.

Section 4006.—No provision.

Effective date.

Applies to services furnished in calendar years after 1989, i.e. 1990. However, it is not effective until the effective date of the 1990 MEI increase as provided for under the bill (and all references to this year shall refer to the portion of the year beginning on such date.)

(b) Limitation on amounts for certain services furnished by more than one specialty.—

Section 10124.—Limits the prevailing charge for certain services to the prevailing charge (or fee schedule amount) applicable to the specialty, designated by the Secretary, that furnishes the service most frequently nationwide. The Secretary is to make designations for services with high Part B expenditures whose prevailing charges differ by specialty.

Specifies that nonparticipating physicians subject to a prevailing charge reductions as a result of this provision are subject to limits on actual charges. In the first year the physician may not charge more than 125% of the reduced prevailing charge plus one-half of the difference between the previous year's maximum allowable actual charge and such reduced prevailing charge; in the second year the limit is 125% of the reduced prevailing charge.

Section 4006.—No provision.

Effective date

Applies to procedures performed after March 31, 1990.

(c) Waiver of liability limiting recoupment in certain cases.—

Section 10124.—No provision.

Section 4006.—Provides that the provisions of Section 1870(c) are to apply where overpayments were made during July 1, 1985–March 31, 1986, as a result of a carrier establishing statewide fees during the process of implementing HCPCS. The Section 1870(c) provisions are to apply, without the need for affirmative action by the physician or an individual, so as to prevent recoupment or decrease in subsequent payments. The provision applies to claims reopened by carriers on or after July 31, 1987.

Effective date

Enactment.

Senate amendment

No provision.

Conference agreement

(a) Customary charge for new physicians.—The conference agreement includes the Senate amendment.

(b) Limitation on amounts for certain services furnished by more than one specialty.—The conference agreement includes the House

provision, with an amendment. It specifies that the limitation applies to surgery, radiology and diagnostic physicians' services.

(c) *Waiver of liability limiting recoupment in certain cases.*—The conference agreement includes the House provision.

6. *Payments for Hospital Outpatient Services*

Section 10131, 10137(e) and section 4013 of House bill and section 5223 of Senate amendment.

Present law

(a) *Payment of capital costs for outpatient hospital services.*—Hospitals' capital-related costs are paid according to reasonable cost principles. OBRA 87 applied a 15 percent reduction to capital payments for inpatient hospital services, but the reduction was not applied to hospital outpatient services.

(b) *Study of payments for services in hospital outpatient departments.*—OBRA 86 required the Secretary to submit an interim report to Congress by April 1, 1988 concerning development of a fully prospective payment system for ambulatory surgery and a final report by April 1, 1989. OBRA 87 modified this directive to the Secretary by requiring him to consult with the Prospective Payment Assessment Commission in preparing the final report. The interim report was submitted in June, 1988, but the final report has not been submitted yet.

House bill

(a) *Payment of capital costs for outpatient hospital services.*—

Section 10131.—Directs the Secretary to issue regulations reducing reimbursements for capital expenses for hospital outpatient department services by 15 percent for cost reporting periods beginning during fiscal 1990. Exempts sole community hospitals from this reduction. Specifies that when payments for hospital outpatient departments are paid on the basis of a blend, the cost portion of the blend includes allocated capital at 85 percent of costs.

Section 4013.—Similar provision, except that (a) applies to portions of cost reporting period occurring during FY 90 and (b) no mention is made of hospitals receiving blended rates under Section 1833(n).

(b) *Study of payments for services in hospital outpatient departments.*—

Section 10137.—Requires the Physician Payment Review Commission to conduct a two part study of factors related to rapid growth in Medicare payments for services in hospital outpatient departments. The first part of the study is to include consideration of the effects of the step-down method used to allocate hospital capital between inpatient and outpatient departments for outpatient hospital costs. It is also to include an assessment of the extent to which hospital outpatient costs were affected by the implementation of the prospective payment system for inpatient hospital services and by increased review of these services by peer review organizations. The

Commission is required to submit a report on this part of the study to Congress by March 1, 1990.

Specifies that the second part of the study is to examine alternative Medicare reimbursement methods for services in hospital outpatient departments. The evaluation is to include prospective payment methods, fee schedules and other methods the Commission deems appropriate. This part of the study is to be submitted to Congress by March 1, 1991 with recommendations on how to reduce the rate of growth in Medicare expenditures for these services.

Effective date

Section 10131.—Enactment.

Section 4013.—Enactment.

Section 10137.—Enactment.

Senate amendment

(a) Payment of capital costs for outpatient hospital services.—

*Section 5232.—*Includes a similar provision to Section 10131, except that the amount of the reduction is 13.5 percent and the exemption also applies to a hospital which is eligible to be paid as a sole community hospital. Further, the reduction does not apply with respect to the capital-related costs of any hospital for a cost-reporting period if it is qualified for a disproportionate share adjustment of at least 5.1 percent in fiscal year 1987.

Provides that the reductions for hospitals paid on a blended rate applies only to that portion of the payment based on hospital costs.

*(b) Study of payments for services in hospital outpatient departments.—*No provision.

Effective date

Enactment.

Conference agreement

*(a) Payment of capital costs for outpatient costs for outpatient hospital service.—*The conference agreement includes the House provisions contained in Section 4013 with a clarification. It specifies that when payments for hospital outpatient departments are paid on the basis of a blend, the cost portion of the blend includes allocated capital at 85 percent of costs.

*(b) Study of payments for services in hospital outpatient department.—*The conference agreement includes the House provision with amendments. The agreement requires the Physician Review Commission to conduct a two part study of factors related to the rapid growth in Medicare payments for services in hospital outpatient departments.

7. Durable Medical Equipment

Section 10132 and 4011 of House bill and section 5222 of Senate amendment.

Present law

(a) *Limitation of rental payments for miscellaneous items and other items of durable medical equipment.*—Under current law, monthly rental payments for “rental cap” items may be made for a maximum of 15 months. Each monthly payment is limited to 10 percent of the recognized purchase price. After 15 months, payment can only be made for maintenance and servicing.

In 1989 and 1990, the recognized purchase price is computed by calculating a base local purchase price and updating it for inflation. The base local purchase price is equal to the average of the purchase prices on claims submitted on an assigned basis for the unused item supplied during the six month period ending with December, 1986.

(b) *Payments for items requiring frequent and substantial servicing.*—Under current law, for items such as ventilators, aspirators, IPPB machines and nebulizers, which require frequent and substantial servicing in order to avoid risk to the patient’s health, payments are made on a monthly basis for rental.

(c) *Delay in and reduction of price update for 1990.*—In current law, fees for five categories of durable medical equipment are scheduled to be updated by the same method in 1990. The categories of equipment are: 1) inexpensive and routinely purchased durable medical equipment; 2) items requiring frequent and substantial servicing; 3) miscellaneous items and other items of durable medical equipment; 4) other covered items, not including durable medical equipment; and 5) oxygen and oxygen equipment. The fee schedule for these items is to be updated in 1990 by the consumer price index for urban consumers (CPI-U) for the six month period ending December 1987.

(d) *Reduction in fee schedule for oxygen and oxygen equipment.*—In current law, reimbursement for oxygen and oxygen equipment during 1989 and 1990 equals 100 percent of the local average monthly payment. The local average monthly payment equals 95 percent of the base local payment amount updated for inflation. The base amount is defined as the total reasonable charges for the item during the 12 month period ending in December 1986 divided by the total number of months for all beneficiaries receiving the item in the area during the 12 month period for which the carrier made payment for the item.

(e) *National cap on fee schedules.*—In current law, six categories of durable medical equipment are established. The fee schedule for each category of equipment is determined using a method specific to each category of equipment, although there are similarities in the methods. There is no cap on fees.

(f) *Coverage of parenteral and enteral nutrition equipment.*—Under current law, parenteral and enteral nutrition nutrients, supplies and equipment, such as intravenous poles and infusion pumps, are excluded from items covered under the durable medical equipment provision.

(g) *Overpriced items.*—Under current law, the Secretary is authorized, effective January 1, 1991, to adjust fees for durable medical equipment using the inherent reasonableness guidelines applied to physicians’ services.

(h) *Restrictions on suppliers.*—

(1) *Prohibitions against distribution by suppliers of forms documenting medical necessity.*—Physicians are required to certify that the durable medical equipment is medically necessary.

(2) *Requirements for disclosing ownership in or control of a durable medical equipment supplier.*—The law requires certain entities participating under Medicare to disclose ownership and related information.

(3) *Carrier review of suppliers in which physicians have ownership interest.*—No provision.

(i) *Mandatory assignment.*—No provision.

(j) *Establishment of reasonable lifetime for items.*—No provision.

(k) *GAO study of standards for use of and payment for durable medical equipment.*—No provision.

(l) *Acceleration of regional rates and narrowing of range of amounts recognized.*—

(1) *Calculation of local and regional prices.*—Under current law, reimbursement for three categories of durable medical equipment is derived from both local and regional price or charge components. The three categories of equipment subject to this reimbursement scheme are: 1) covered items, other than durable medical equipment; 2) miscellaneous and other items of durable medical equipment; and 3) oxygen and oxygen equipment. Although the determinants of local and regional prices differ for each of the three categories of equipment, payments for all three categories of equipment have the same proportion of local and regional price components in their reimbursement structure. Payment amounts are determined as follows: payments in 1989 and 1990 are equal to 100 percent of the local purchase price; payments in 1991 are based on 75 percent of the local purchase price and 25 percent of the regional purchase price; in 1992, payments are based on 50 percent of the local purchase price and 50 percent of the regional purchase price; and, in 1993 and subsequent years, payments are based solely on regional purchase prices.

(2) *Limits on ranges of amounts recognized.*—Under current law, limits are established on the range of purchase prices recognized for covered items, other than durable medical equipment; miscellaneous and other items of durable medical equipment; and oxygen and oxygen equipment. No limit is established for 1990. In 1991, the recognized purchase price for an item may not exceed 130 percent, nor be lower than 80 percent of the average for all carrier service areas in the U.S. In 1992, the range may not exceed 125 percent nor be lower than 85 percent of the average. Similar limits are applied for the range of monthly payment amounts recognized for oxygen and oxygen equipment.

(m) *Power-driven wheelchairs.*—Power driven wheelchairs are not specifically included in any category of durable medical equipment under current law. As a matter of practice, they are treated as miscellaneous and other covered items of durable medical equipment.

(n) *Ostomy supplies defined as part of home health services.*—Under current law, ostomy supplies are not specifically included in

the definition of home health services. Current law includes medical supplies in the definition of home health services. Medical supplies are defined by exclusion, rather than inclusion. Drugs and biologicals are specifically excluded from medical supplies, but there is no further delineation as to what constitutes medical supplies.

House bill

(a) Limitation of rental payment for miscellaneous items and other items of durable medical equipment.—

Section 10132.—Limits monthly rental payments to 10 percent of the recognized purchase price for the first three months and 7.5 percent of the recognized purchase price for the next twelve months.

Changes the computation of the base local purchase price to the average of reasonable charges on claims paid on an assigned basis.

Section 4011.—No provision.

(b) Payments for items requiring frequent and substantial servicing.—

Section 10132.—Limits monthly rental payments for items requiring frequent and substantial servicing to a fifteen month period. Directs the Secretary to establish a maintenance and servicing payment for these items during the last month of every six month period following the initial fifteen months. The payment is for reasonable and necessary maintenance and servicing of the item, and is to include payment for parts and labor not covered by the supplier's or manufacturer's warranty.

Section 4011.—No provision.

(c) Delay in and reduction of price update for 1990.—

Section 10132.—Delays the DME fee schedule update for 1990 until April 1, 1990 and limits the amount of the update to 2 percent instead of the CPI-U.

Section 4011.—No provision.

(d) Reduction in fee schedule for oxygen and oxygen equipment.—

Section 10132.—Reduces the fee schedule amount for payment of oxygen and oxygen equipment from April 1, 1990 through December 31, 1990 to 95 percent of the local average monthly payment rate, increased by the applicable update factor.

Section 4011.—No provision.

(e) National cap on fee schedules.—

Section 10132.—Establishes a cap on fees for the all categories of durable medical equipment except customized items. The cap is established at 95 percent of the median of the amounts that would otherwise be paid under the fee schedule. Also includes a cap on the fee schedule for IV poles, which are added to the category of inexpensive and frequently purchased equipment.

Section 4011.—No provision.

(f) Coverage of parenteral and enteral nutrition equipment.—

Section 10132.—Includes parenteral and enteral nutrition equipment in the items included under the durable medical

equipment provision. Maintains the exclusion of parenteral and enteral nutrition nutrients and supplies.

Includes IV poles in the category of inexpensive and routinely purchased durable medical equipment. Authorizes reimbursement for IV poles in 1990 at the average reasonable charge in the area for purchase or rental of the item in the 12-month period ending June 30, 1988, increased by the CPI-U for the 12 month period ending with June 1989. In subsequent years, the fee is the previous year's fee updated by the CPI-U for the 12 month period ended the previous June.

Section 4011.—Contains similar provision with respect to coverage of parenteral and enteral nutrition equipment. No provision regarding IV poles.

(g) Overpriced items.—

(1) Inherent reasonableness.—

Section 10132.—Removes restriction permitting the Secretary to apply inherent reasonableness guidelines only after January 1, 1991, thus permitting the Secretary to make inherent reasonableness adjustments after the effective date of this subsection.

Section 4011.—No provision

(2) Reduction in fee schedule for certain specified items

Section 10132.—Directs the Secretary to reduce the payment amounts for seat-lift chairs, motorized scooters, and transcutaneous electrical nerve simulators by 15 percent for items furnished on or after April 1, 1990.

Section 4011.—Directs the Secretary to reduce the payment amounts for seat-lift chairs, power operated vehicles or transcutaneous electrical nerve simulators by 15 percent.

(3) Reduction in fee schedule for other overpriced items

Section 10132.—Directs the Secretary to publish a list of items which he has determined are overpriced and further directs the Secretary to reduce payments for these items by 15 percent beginning in the fourth month after publication of the list.

Section 4011.—No provision.

(h) Restrictions on suppliers.—

(1) Prohibitions against distribution by suppliers of forms documenting medical necessity

Section 10132.—Prohibits suppliers of durable medical equipment from distributing for commercial purposes to individuals eligible for Part B services any partially or fully completed forms required by the Secretary to document medical need for an item of durable medical equipment. Subjects suppliers who violate this prohibition to exclusion from Medicare or to civil money penalties not exceeding \$1,000 for each form distributed.

Section 4011.—No provision.

(2) Requirements for disclosing ownership in or control of a durable medical equipment supplier

Section 10132.—Directs the Secretary to promulgate a regulation requiring durable medical equipment suppliers to provide the Sec-

retary with complete information concerning the identity of each person having at least a 5% ownership or control interest in the supplier or at least a 5 percent ownership interest in any subcontractor. Suppliers must provide this information to the Secretary as a condition of payment for covered items and must also inform the Secretary if any of the people having such interest are physicians.

Stipulates that suppliers who are not eligible for Medicare reimbursement due to failing to comply with this provision can not bill beneficiaries for these items.

Section 4011.—No provision.

(3) Carrier Review of suppliers in which physicians have ownership interest

Section 10132.—Requires Medicare carriers to subject claims from suppliers of durable medical equipment, prosthetic devices, orthotics and prosthetics in which a physician has an ownership or control interest of at least 5 percent to a higher standard of review than claims from suppliers not having such ownership or control.

Section 4011.—No provision.

(i) Mandatory assignment.—

Section 10132.—Mandates billing and payment for durable medical equipment on an assignment-related basis only. Subjects suppliers who repeatedly violate this provision to exclusion from Medicare for up to five years or civil money penalties, or both.

Section 4011.—No provision.

(j) Establishment of reasonable lifetime for items.—

Section 10132.—Directs the Secretary to determine and establish a reasonable lifetime for two categories of durable medical equipment: equipment requiring frequent and substantial servicing and other items of durable medical equipment. If the reasonable lifetime for an item is reached during a continuous period of medical need, payment for a replacement may be made in accordance with the payment principles established for the category of equipment.

Section 4001.—No provision.

(k) GAO Study of standards for use of and payment for durable medical equipment.—

Section 10132.—Requires the Comptroller General to conduct a study of the appropriate uses of durable medical equipment and of the appropriate criteria for making determinations of medical necessity in the Medicare program. The study is to place particular emphasis on items, including seat-lift chairs that may be subject to abusive billing practices. The study is to include an analysis of the appropriate use of medical necessity forms and procedures for identifying items that should no longer be covered by Medicare. In conducting the study, the Comptroller General is directed to convene a panel consisting of the following: 1) specialists in orthopedic medicine, rehabilitation, arthritis, and geriatric medicine; 2) representatives of consumer organizations; and 3) representatives of carriers participating in Medicare. The report is to be submitted by April 1, 1990 to the House Committees of Ways and Means and Energy and Commerce and the Senate Finance Committee and

is to include recommendations that the Comptroller General deems appropriate.

Section 4011.—No provision.

(l) Acceleration of regional rates and narrowing of range of amounts recognized.—

(1) Calculation of local and regional prices

Section 10132.—No provision.

Section 4011.—Accelerates the transition to payments based solely on regional prices by eliminating payments based only on local payment amounts in 1990. Instead, payments in 1990 are based on 75 percent local prices and 25 percent regional prices. In 1991, the mix is 50 percent local prices and 50 percent regional prices. In 1992 and subsequent years, payments are based solely on regional prices.

(2) Limits on ranges of amounts recognized

Section 10132.—No provision.

Section 4011.—Restricts the ranges of recognized purchase prices or payment amounts and accelerates the restriction of such ranges. In 1990, the recognized purchase prices or payment amounts may not exceed 125 percent, nor be lower than 85 percent of the average for all carrier service areas in the U.S. In 1992, the range is between 120 percent and 90 percent of the average.

(m) Power-driven wheelchairs

Section 10132.—No provision.

Section 4011.—Explicitly defines power-driven wheelchairs as a separate type of inexpensive or routinely purchased durable medical equipment.

(n) Ostomy supplies defined as part of home health services.—

Section 10132.—No provision.

Section 4011.—Includes ostomy supplies (as defined by the Secretary) provided under a plan established by a home health agency and periodically reviewed by a physician in the definition of home health services. Specifies that ostomy supplies are not included in the definition of durable medical equipment. Requires home health agencies to provide ostomy supplies to Medicare beneficiaries who need such supplies as part of their services.

Effective date.—Section 10132—Enactment, except (a) and (b) apply with respect to payment for items of DME furnished on or after April 1, 1990. Section (h) (1) and (2) apply to forms and documents distributed on or after April 1, 1990. Section (h)(3) applies with respect to covered items furnished on or after April 1, 1990. Sections (j) and (i) apply with respect to covered items furnished on or after April 1, 1990.

Section 4011.—Applies with respect to covered items furnished on or after January 1, 1990 except that Section (m) is effective October 1, 1989.

Senate amendment

(a) Limitation of rental payments for miscellaneous items and other items of durable medical equipment.—No provision.

(b) *Payments for items requiring frequent and substantial servicing.*—No provision.

(c) *Delay in and reduction of price update for 1990.*—Similar provision to Section 10132, except that amount of the update is 3 percent.

(d) *Reduction in fee schedule for oxygen and oxygen equipment.*—No provision.

(e) *National cap on fee schedules.*—No provision.

(f) *Coverage of parenteral and enteral nutrition equipment.*—No provision.

(g) *Overpriced items.*—

(1) *Inherent reasonableness.*—No provision.

(2) *Reduction in fee schedule for certain specified items.*—Similar provision to Section 10132, except that motorized scooters are not mentioned.

(3) *Reduction in fee schedule for other overpriced items.*—No provision.

(h) *Restrictions on suppliers.*—

(1) *Prohibitions against distribution by suppliers of forms documenting medical necessity.*—No provision.

(2) *Requirements for disclosing ownership in or control of a durable medical equipment supplier.*—No provision.

(3) *Carrier review of suppliers in which physicians have ownership interest.*—No provision.

(i) *Mandatory assignment.*—No provision.

(j) *Establishment of reasonable lifetime for items.*—No provision.

(k) *GAO study of standards for use of and payment for durable medical equipment.*—

Section 5225.—No provision.

(l) *Acceleration of regional rates and narrowing of range of amounts recognized.*—

(1) *Calculation of local and regional prices.*—No provision.

(2) *Limits on Ranges of Amounts Recognized.*—No provision.

(m) *Power-driven wheelchairs.*—Explicitly defines power-driven wheelchairs as a separate type of inexpensive or routinely purchased durable medical equipment, excluding a customized power-driven wheelchair defined as such by the Secretary. Directs the Secretary to specify, through regulation, criteria to be used by carriers in making determinations on a case-by-case basis in determining whether a power-driven wheelchair is a customized item or is to be classified as routinely purchased durable medical equipment.

(n) *Ostomy supplies defined as part of home health services.*—No provision.

Effective date

Section 5222.—Applies with respect to items furnished on or after April 1, 1990, except that the provision directing the Secretary to issue regulations on customized items is effective upon enactment.

Conference agreement

(a) *Limitation of rental payment for miscellaneous items and other items of durable medical equipment.*—The conference agreement does not include the House provision.

(b) *Payments for items requiring frequent and substantial servicing.*—The conference agreement does not include the House provision.

(c) *Delay in and reduction of price update for 1990.*—The conference agreement includes the House provision with an amendment which specifies that the MEI update for 1990 is zero percent.

(d) *Reduction in fee schedule for oxygen and oxygen equipment.*—The conference agreement included no provision.

(e) *National cap on fee schedules.*—The conference agreement included no provision.

(f) *Coverage of parenteral and enteral nutrition equipment.*—The conference agreement establishes a cap of 15 months on rental payments under the enteral and parenteral fee schedule, and requires the Secretary to provide for reasonable maintenance and servicing fees to be paid after the period of rental payments has expired, effective April 1, 1990.

(g) *Overpriced items.*—

(i) *Inherent reasonableness.*—The conference agreement included no provision.

(ii) *Reduction in fee schedule for certain specified items.*—The conference agreement includes the Senate amendment.

(iii) *Reduction in fee schedule for other overpriced items.*—The conference agreement included no provision.

(h) *Restrictions on suppliers.*—The conference agreement included no provision.

(i) *Mandatory assignment.*—The conference agreement included no provision.

(j) *Establishment of reasonable lifetime for items.*—The conference agreement included no provision.

(k) *GAO study of standards for use of and payment for durable medical equipment.*—The conference agreement includes Section 10132 of the House provision with a requirement that the Comptroller's report be submitted not later than April 1, 1991.

(l) *Acceleration of regional rates and narrowing of range of amounts recognized.*—The conference agreement includes Section 4011 of the House provision with respect to limits on ranges of amounts recognized.

(m) *Power-driven wheelchairs.*—The conference agreement includes the Senate amendment.

(n) *Ostomy supplies defined as part of home health services.*—The conference agreement includes the House provision with amendments.

8. Clinical Diagnostic Laboratory Services

Section 10133 and 4012 of House bill and section 5221 of Senate amendment.

Present law

(a) Fee schedule update for 1990

Under current law, the Secretary is directed to update the clinical laboratory fee schedule on January 1 of each year by a percentage increase or decrease in the consumer price index of all urban consumers (U.S. city average). The Secretary may make other ad-

justments he deems justified by technological changes. No update was permitted in 1988 and no catch-up is permitted in subsequent years.

(b) Reduction of limitation amount on payment amount

Under current law, clinical diagnostic laboratory services are reimbursed on the basis of a fee schedule established on a regional, state-wide or carrier service area at the discretion of the Secretary. As a matter of practice, the Secretary has established fee schedules on a carrier service basis. A ceiling limits payment that can be made for a laboratory test to the median of all the fee schedules established for that test in that laboratory setting. This ceiling was imposed on April 1, 1988, and is slated to remain in effect until a nationwide fee schedule is implemented.

(c) Establishment of nationwide fee schedule

Under current law, a nationwide fee schedule is to be established for clinical diagnostic laboratory tests furnished on or after January 1, 1990. A separate nationwide fee schedule is established for tests furnished by sole community hospitals.

(d) Payments of fees to certain labs for additional trips for tests requiring "stat" results

Under current law, the Secretary is authorized to establish a nominal fee to cover the appropriate costs of collecting a laboratory sample and a fee to cover transportation and personnel expenses for trained personnel to travel to a person who is homebound or an inpatient in an inpatient facility which is not a hospital. Only one fee may be established for samples collected in the same encounter. The method for computing the fee for transportation and personnel expenses is to be based on the number of miles and the personnel costs involved in collecting the sample. However, this method for computing the fee applies only to tests furnished between April 1, 1989 and December 30, 1990 and only to laboratories that establish, to the Secretary's satisfaction, the following qualifications: 1) that the laboratory depends on Medicare payments for at least 80 percent of its collected revenues for clinical diagnostic laboratory tests; 2) at least 85 percent of the laboratory's gross revenue for tests are for tests performed for individuals who are homebound or resident in a nursing facility; and 3) the laboratory provides tests for residents in nursing facilities representing at least 20 percent of the number of nursing facilities in the state in which the laboratory is located. In establishing these qualifications, laboratories must use data for the twelve month period ended June 30, 1988. The law also requires the Secretary to adjust the fees for transportation and personnel in such a manner that total costs for clinical lab fees are not greater than they would have been in the absence of the adjustment for transportation and personnel.

(e) Restriction on payment to referring laboratory

Current law restricts payment for clinical diagnostic laboratory tests to the person or entity which performed or supervised the performance of the tests, with a few exceptions. One exception provides that in the case of a test performed by one laboratory at the

request of another laboratory, payment may be made to the referring laboratory.

(f) Repeal of State certification of high-volume physician office labs

OBRA 87 required high volume physician office laboratories performing over 5,000 tests a year (including Medicare and non-Medicare) to meet the same conditions for participation in Medicare as those required of independent laboratories. The effect of this provision is that high volume physician laboratories must be licensed under state law if licensure is required of independent laboratories and must meet other conditions established by the Secretary to assure the health and safety of the people for whom the tests are performed.

House bill

(a) Fee schedule update for 1990

Section 10133.—Prohibits the Secretary from making an adjustment to the fee schedule to account for changes in the consumer price index in 1989. [drafting error] Stipulates that the 1990 annual adjustment to the fee schedule is an increase of 2 percent.

Section 4012.—No provision.

(b) Reduction of limitation amount on payment amount

Section 10133.—Maintains the ceiling on fee schedule payments at 100 percent of the median for a particular test in a particular laboratory setting through December 31, 1989. Establishes the ceiling on fee schedule payments at 95 percent of the median for a particular test in a particular laboratory setting beginning January 1, 1990 until such time as a nationwide fee schedule is established for that test in that laboratory setting.

Section 4012.—Establishes the ceiling on fee schedule payments at 95 percent of the median of all the fee schedules established for that test in that particular laboratory setting beginning January 1, 1990 and continuing indefinitely.

(c) Establishment of nationwide fee schedule

Section 10133.—Delays the implementation of the nationwide fee schedule for two years, until January 1, 1992.

Section 4012.—Eliminates the requirement for a nationwide fee schedule.

(d) Payments of fees to certain labs for additional trips for tests requiring "Stat" results

Section 10133.—Deletes qualifications relating to Medicare dependency and percentage of statewide test laboratories must demonstrate to the Secretary in order to receive a fee for transportation and personnel costs associated with collecting a sample from people who are homebound or institutionalized in nursing facilities. The requirement to demonstrate that at least 85 percent of the tests are performed on homebound people or residents of nursing homes remains. Provides payment to qualifying laboratories for a second fee for transportation and personnel on the same day to

cases where an individual's physician has ordered a laboratory test for which results are required on an as-soon-as-possible ("stat") basis.

Section 4012.—No provision.

(e) Restriction on payment to referring laboratory

Section 10133.—No provision.

Section 4012.—Restricts the payment for clinical diagnostic laboratory tests to a referring laboratory only if the referring laboratory is located in, or is part of a rural hospital, or if not more than 30 percent of the tests for which the referring laboratory submits bills or requests payments within a year are performed by another laboratory.

(f) Repeal of State certification of high-volume physician office labs

Section 10133.—No provision.

Section 4012.—Repeals the requirement that high volume physician labs comply with the same State and Federal requirements as independent laboratories.

Effective date

Section 10133.—Applies to tests furnished on or after January 1, 1990.

Section 4012.—Enactment, except: (e) applies with respect to clinical diagnostic laboratory tests performed on or after January 1, 1990, and (f) is effective as if included in the enactment of OBRA—1987.

Senate Amendment

(a) Fee schedule update for 1990

Section 5221.—Stipulates that the 1990 annual adjustment to the fee schedule is an increase of 3 percent, effective April 1, 1990.

(b) Reduction of limitation amount on payment amount

Identical provision to Section 10133.

(c) Establishment of nationwide fee schedule

No provision.

(d) Payments of fees to certain labs for additional trips for tests requiring "stat" results

No provision.

(e) Restriction on payment to referring laboratory

No provision.

(f) Repeal of State certification of high-volume physician office labs

No provision.

Effective date

Enactment.

Conference agreement

(a) *Fee schedule for 1990.*—The conference agreement included no provision.

(b) *Reduction of limitation amount on payment amount.*—The conference agreement includes the House provision contained in Section 10133, with an amendment. It established the ceiling on fee schedule payments at 93 percent of the median for a particular test in a particular laboratory setting beginning January 1, 1990.

(c) *Establishment of nationwide fee schedule.*—The conference agreement includes the House provision contained in Section 4012.

(d) *Payment of fees to certain labs for additional trips for test requiring "stat" results.*—The conference agreement included no provision.

(e) *Restriction on payment to referring laboratory.*—The conference agreement includes the House provision with an amendment; however, it does not restrict the payment for clinical diagnostic laboratory tests to a referring laboratory if the referring laboratory is a wholly-owned subsidiary of the entity performing the test, or both the referring laboratory and the entity performing the test are wholly owned by a third entity. Stipulates that the restrictions apply to clinical diagnostic laboratory tests performed on or after January 1, 1990.

(f) *Repeal of State certification of high-volume physician office labs.*—The conference agreement includes 4012 of the House provision with an amendment that such laboratories meet the certification requirements of the Clinical Laboratory Improvement Act of 1988.

(g) *Moratorium on laboratory demonstration.*—The conference agreement included no provision.

9. Mental Health Services

Section 10134 and 4021 of House bill and section 5233 and 5237 of Senate bill.

Present law

(a) Medicare reimbursement for psychologists' services

Under current law, Medicare reimbursement for psychologists' services is limited to services furnished by clinical psychologists in risk-contracting health maintenance organizations (HMOs), rural health clinics, and community mental health centers (CMHCs) and services furnished off-site from a CMHC because of the inability of the patient to travel to the center because of physical or mental impairment, institutionalization or a similar reason.

(b) Reimbursement on reasonable charge basis

Under current law, reimbursement for services of qualified psychologists furnished by or offsite from a CMHC is 80 percent of the lesser of the actual charge for services or a fee schedule established by the Secretary.

(c) *Development of criteria regarding consultation with a physician*

No provision.

(d) *Elimination of dollar limitation for mental health services*

Under current law, payment in any year for outpatient mental health services for treatment of mental, psychoneurotic, and personality disorders is limited to the lesser of \$1,375 or 62.5 percent of reasonable charges. After beneficiaries have paid coinsurance of 20 percent, payment for 62.5 percent of the remaining expenses is equal to payment of 50 percent of reasonable charges.

(e) *Definition of psychologist*

In current law, the Secretary is authorized to determine the qualifications for a clinical psychologist.

(f) *Coverage of clinical social worker services*

Under current law, services of clinical social workers are reimbursable only if they are provided pursuant to a contract with a risk-based organization (HMO). Current law defines clinical social workers, but not clinical social worker services.

House Bill

(a) *Medicare reimbursement for psychologists' services*

Section 10134.—Removes current restrictions on clinical psychologists' services. Services of clinical psychologists are reimbursable if they would otherwise be covered if they were furnished by physicians or as incident to physicians' services and as long as the psychologists are practicing within the scope of state licenses.

Section 4021.—Identical provision

(b) *Reimbursement on reasonable charge basis*

Section 10134.—Deletes current reimbursement, thus providing that psychologists' services are reimbursable on the basis of reasonable charges.

Section 4021.—No provision.

(c) *Development of criteria regarding consultation with a physician*

Section 10134.—Requires the Secretary to develop criteria covering direct reimbursement to qualified psychologists. The criteria must include an agreement by qualified psychologists that they will consult with patients' attending physicians within a reasonable period of time after initiating treatment. The purpose of the consultation is to consider potential physical conditions that may be contributing to patients' symptoms. The Secretary is required to consider patient confidentiality in developing these criteria.

Section 4021.—Directs the Secretary to require qualified psychologists and clinical social workers (whose services are added as Medicare reimbursable services under another provision in this section) to document the following in patients' records: 1) that the practitioner has informed the patient of the desirability of confer-

ring with his primary care physician to consider potential medical conditions contributing to their condition; and 2) that the practitioner has provided written notification to the patient's attending physicians that mental health services are being provided, or that the practitioner has consulted directly with the attending physician to consider medical conditions which may be contributing to the patient's condition. If a patient specifically requests that such notification or consultation not be made, the physician is not required to notify or consult with the attending psychologist or social worker.

(d) Elimination of dollar limitation for mental health services

Section 10134.—Eliminates the provision limiting payment for mental health services to \$1,375 per year.

Section 4021.—Identical provision.

(e) Definition of psychologist

Section 10134.—No provision.

Section 4021.—No provision.

(f) Coverage of clinical social worker services

Section 10134.—No provision

Section 4021.—Includes clinical social worker services as a Medicare reimbursable service. Defines clinical social worker services as services provided by a clinical social worker for the diagnosis and treatment of mental illnesses which the clinical social worker is legally authorized to perform under State law (or the State regulatory mechanism provided by State law) of the State in which such services are performed. The services must be those that would be covered if furnished by a physician or as an incident to a physician's services. Reimbursement for clinical social worker services is on the basis of reasonable charges.

Effective date

Section 10134.—Provisions (a), (b), and (c) are effective January 1, 1990. Provision (d) is effective for expenses incurred in a year beginning in 1990. *Section 4021.*—Provisions (a), (b), (c) and (e) are effective January 1, 1990. Provision (d)—Applies to expenses incurred in a year beginning in 1990.

Senate amendment

(a) Medicare reimbursement for psychologists' services

Section 5233.—Similar provision.

(b) Reimbursement on reasonable charge basis

Section 5233.—Similar provision to section 10134.

(c) Development of criteria regarding consultation with a physician

No provision.

(d) Elimination of dollar limitation for mental health services

Section 5233.—Identical provision to section 10134.

(e) Definition of psychologist

Section 5233.—Defines psychologist or qualified psychologist as a person with the following qualifications: (1) a license or certification at the independent practice level of psychology by the state in which the person practices; (2) a doctoral degree in psychology from a regionally accredited educational institution; or in the case of an individual licensed or certified prior to January 1, 1978, a master's degree in psychology and a listing in a national register of mental health services in psychology approved by the Secretary; and (3) at least two years of supervised experience in health service, at least one year of which is postgraduate.

(f) Coverage of clinical social worker services

Section 5237.—Identical provision to section 4021.

Effective date

Provision (a), (b), and (e)—Apply to services performed on or after January 1, 1990. Provision (d) applies to expenses incurred in a year beginning in 1990. Provision (f)—Enactment.

Conference agreement

(a) Medicare reimbursement for psychologists' services.—The conference agreement includes the House provision.

(b) Reimbursement on reasonable charge basis.—The conference agreement included no provision.

(c) Development of criteria regarding consultation with a physician.—The conference agreement includes the House provision contained in Section 10134. The conferees intend that the criteria developed by the Secretary stipulate that the patient's medical record include documentation that: (1) the psychologist or clinical social worker has informed the patient of the desirability of conferring with the patient's primary care physician to consider potential medical conditions contributing to the patient's condition; and (2) the psychologist or clinical social worker has provided written notification to the patient's designated attending physician that services are being provided to the patient, or has consulted directly with the physician to consider medical conditions that may be contributing to the patient's symptoms, unless the patient specifically requests that such notice or consultation not be made.

(d) Elimination of dollar limitation for mental health services.—The conference agreement includes the House provision.

(e) Definition of psychologist.—The conference agreement included no provision.

(f) Coverage of clinical social worker services.—The conference agreement includes the House provision with an amendment. It excludes services furnished by a clinical social worker to an inpatient of a hospital and services furnished to an inpatient of a skilled nursing facility which the facility is required to provide as a requirement for participation in Medicare. It specifies that reim-

bursement to clinical social workers is to be 80 percent of the lesser of the actual charge for the service or 75 percent of the amount paid to a psychologist. Stipulates that payment may only be made on an assignment-related basis.

10. Payments for Other Services

Sections 10135, 10136, 10137(f)–(g), 4004 (b)–(d), 4014, 4017, 4022, 4024 of House bill.

Present law

(a) Certified registered nurse anesthetists (CRNAs)

(1) Conversion factors of CRNAs.—OBRA 86 provided for direct reimbursement of certified registered nurse anesthetists on an assigned basis for a two year period beginning January 1, 1989. Reimbursement to CRNAs would be the lesser of actual charges or a fee schedule established by the Secretary. The Secretary was authorized to develop a fee schedule using a methodology similar to the fee schedule for anesthesiology (i.e. using base, time and modifier units). OBRA 87 mandated that aggregate reimbursement for CRNA services under the fee schedule not exceed total payments that would have been made in 1989 and 1990 under the previous reimbursement methodology. In addition, it stipulated that the initial fee schedule must be based on audited data from cost reporting periods ending in FY 85 and trended forward using the MEI.

Regulations implementing the fee schedule were proposed in January, 1989, but have not been finalized yet. Proposed regulations are currently being implemented through carrier instructions. The Secretary's proposed regulations incorporated the base, time and modifier unit concepts and a conversion factor. Because of the budget neutrality requirements, the conversion factors used in the fee schedule proposal were considerably lower than anticipated, in comparison to hospital costs.

(2) Medical direction of CRNAs.—Current law does not prohibit a surgeon from being reimbursed for medical direction of a CRNA during a surgical procedure that is being performed by that surgeon. As a matter of practice, some Medicare contractors permit it, while others do not.

(3) Extension of the pass-through for CRNA services in rural hospitals.—Under current law, rural hospitals are permitted to exclude costs for CRNA services from the prospective payment system and be reimbursed for them on a cost basis if they meet specified conditions. Rural hospitals must have established these conditions to the Secretary's satisfaction prior to April 1, 1989 in order to be eligible for pass-through payments. Less than 250 surgical procedures (including both inpatient and outpatient procedures) must have been performed in the hospital during 1987. Prior to the beginning of subsequent years, the hospital must determine that it will perform less than 250 surgical procedures in the following year. Not more than one full-time equivalent CRNA may be employed by or under contract to the hospital and the CRNA must agree not to bill Medicare Part B directly for services. The pass-through exemption from the prospective payment system is effective for 1989, 1990 and 1991.

(b) Nurse practitioner services, clinical nurse specialist services and assistants at surgery

(1) Services and reimbursement for nurse practitioners and clinical nurse specialists.—Under current law, services of nurse practitioners are covered by Medicare in specified circumstances, as follows: (1) services provided in rural health clinics, or as incident to such services in rural health clinics if these services would be covered if provided by physicians; (2) services incident to physicians' services; and (3) services furnished in a health maintenance organization or competitive medical plan and services incident to these services if they would be covered if furnished by physicians.

Medicare reimbursement for these services varies by the setting in which services are performed. Nurse practitioner services performed in rural health clinics are reimbursed either on a reasonable cost basis or under the all-inclusive rate established for rural health centers. Reimbursement for services performed incident to physician services is included in reimbursement made to physicians. For nurse practitioner services rendered in a cost-based HMO or CMP, payment is included as part of reasonable cost reimbursement. No additional payment is authorized for nurse practitioner services rendered in risk-based HMOs or CMPs.

Services of clinical nurse specialists are covered as incident to a physician's services if they would be covered if provided by a physician.

OBRA 86 authorized coverage of physicians' assistants furnished under the supervision of a physician in a hospital, skilled nursing facility, intermediate care facility or as an assistant at surgery. Physicians' assistants must be legally authorized to perform those services in the State in which they are performed. Services and supplies furnished incident to these services are covered if they would be covered when furnished incident to physicians' services.

Physicians' assistants services are subject to a prevailing charge screen equal to 85 percent of the prevailing charge for comparable physicians' services furnished by nonspecialist physicians when these services are performed in skilled nursing facilities or intermediate care facilities. The prevailing charge screen is equal to 75 percent of the nonspecialist physicians' prevailing charge when services are performed in a hospital and 65 percent of the reasonable charge for a physician when acting as an assistant at surgery.

(2) Payment for routine visits by members of a team.—No provision.

(3) Reduction in payment to avoid duplicate payment.—No provision.

(4) State demonstration projects on visit limitations.—No provision.

(5) GAO study of payment for services of nurse practitioners and clinical nurse specialists.—No provision.

(6) Study of payments for assistants at surgery.—Current law provides for reimbursement for assistants at surgery on the basis of reasonable charges only if the services (1) are required due to exceptional medical circumstances; (2) are performed by team physicians needed to perform complex medical procedures; (3) constitute concurrent medical care relative to a medical condition that re-

quires the presence of, and active care by, a physician of another specialty during surgery; or (4) are medically required and are furnished by a physician who is primarily engaged in surgery and the primary surgeon does not use interns and residents in the surgical procedures the physician performs. However, reasonable charge reimbursement is prohibited in hospitals with a training program relating to the medical specialty required for the surgical procedure and a qualified individual on the staff of the hospital is available to serve as an assistant at surgery.

Payment for an assistant at surgery is limited to 20 percent of the local prevailing charge, adjusted by the Medicare economic index (MEI), the surgical procedure performed by the primary surgeon. If conditions (2) and (3) above are met, payment is made on the basis of reasonable charges consistent with the prevailing practice in the area rather than at the special assistant at surgery rate.

Physicians' assistants may also serve as assistants at surgery. While acting as an assistant at surgery, reimbursement is limited to 65 percent of the amount that would be paid to a physician acting as an assistant at surgery.

(c) Federally qualified health centers

(1) inclusion of federally qualified health center services in medicare benefits.—Medicare law provides for reimbursement of rural health clinic services on the basis of costs which are reasonable and related to the costs of furnishing such services or which are based on such other tests of reasonableness as the Secretary prescribes by regulation.

(2) Medicare payment for federally qualified health center services.—Medicare law provides for reimbursement of rural health clinic services on the basis of costs which are reasonable and related to the costs of furnishing such services or which are based on such other tests of reasonableness as the Secretary prescribes by regulation.

Current regulations governing reimbursement for rural health clinic services provide for reimbursement of clinics which are integral and subordinate parts of a Medicare participating hospital, skilled nursing facility or home health agency on the basis of the reasonable cost principles. All other rural health clinics, called independent clinics, are paid an all-inclusive rate for each beneficiary visit for covered services. The all-inclusive rate is determined by the carriers at the beginning of each reporting period. The rate is determined by dividing the estimated total allowable costs by estimated total visits for rural health clinic services. Rates are subject to reasonableness tests, and are reviewed periodically during each reporting period to assure that payments approximate actual allowable costs and visits.

Carriers adjust rates in the following circumstances: 1) there is a significant change in the utilization of clinic services; 2) actual allowable costs vary materially from the clinic's estimated allowable costs; or other circumstances arise which warrant an adjustment. Payments are also subject to reconciliation to assure that they do not exceed or fall short of allowable costs for covered services delivered to covered beneficiaries.

(3) Waiver of part B deductible.—No provision.

(4) *Requirements governing Medicare payments in specified circumstances.*—Under current law, Medicare payments generally may not be made in a number of specified circumstances, including where the person receiving the service has no legal obligation to pay or because a governmental entity (other than Medicare or a governmental entity providing health insurance benefits) is paying for such services directly or indirectly. Rural health clinic services are exempt from this requirement.

(5) *Exemption from anti-kickback requirement.*—Current law prohibits providers or others furnishing services or supplies to Medicare beneficiaries from knowingly or willfully soliciting, receiving, offering to pay or paying any remuneration (including any kickback, bribe, or rebate) directly or indirectly, in cash or in kind in return for the following: 1) furnishing or arranging to furnish an item or service for which Medicare or any State health program will pay; and 2) purchasing, leasing, ordering a good, facility, service, or item for which partial or full payment can be made under Medicare or any State health program. Those who violate these prohibitions are guilty of a felony and are subject to a fine of up to \$25,000 and imprisonment for up to 5 years.

(d) *Rural health clinic services*

(1) *Staffing requirements; inclusion of certified nurse midwife.*—Current law does not regulate staffing requirements of rural health centers. Regulations require that a nurse practitioner or physician assistant be available to furnish patient care services at least 60 percent of the time a clinic operates.

(2) *Coverage of clinical social worker and certified nurse midwife services.*—No provision.

(3) *Expansion of Areas Eligible for Rural Health Center Status.*—Under current law, facilities must meet specified criteria to be designated as rural health clinics. They must be located in an area that the Bureau of the Census has designated as not urbanized and that has been designated by the Secretary as either: 1) an area with a shortage of personal health services under the Public Health Service Act; or 2) an area designated under the same Act as a health manpower shortage area because of its shortage of primary medical care manpower.

(4) *Dissemination of rural health clinic information.*—No provision.

(5) *Treatment of certain facilities as rural health clinics.*—No provision.

House Bill

(a) *Certified Registered Nurse Anesthetists (CRNAs)*

(1) *Conversion factors of CRNAs.*—

Section 10135.—Requires the Secretary to establish a uniform national conversion factor for CRNA services in 1990. The uniform national conversion factor is to be \$14 for services furnished under the medical direction of a physician and \$21 for other services, except that these conversion factors may not exceed the conversion factor for anesthesiologists' services in the same locality. The exception would not apply in the case of

services furnished in a facility where no anesthesiologist furnishes services.

Section 4004.—Similar provision; however, the limitation on the CRNA conversion factor applies whenever there is no physician furnishing anesthesia services.

(2) *Medical direction of CRNAs.*—

Section 10135.—Codifies a proposed regulation that prohibits the reimbursement of surgeons for medical direction of CRNAs. Establishes a penalty for surgeons knowingly and willfully violating this prohibition. The penalty may include exclusion from the Medicare program and civil monetary penalties.

Section 4004.—Similar provision with different effective date.

(3) *Extension of the pass-through for CRNA services in rural hospitals.*—

Section 10135.—No provision

Section 4004.—Raises the number of inpatient and outpatient surgical procedures that may be performed in rural hospitals qualifying for the cost based reimbursement exemption from the prospective payment system from 250 to 500. Makes the pass-through exemption part of permanent law and permits the rural hospital to establish that it has met the conditions at any time before the year the pass-through is sought.

Effective date

Section 10135.—Applies to services furnished on or after April 1, 1990.

Section 4004.—Applies to services furnished on or after January 1, 1990.

(b) *Nurse practitioner services, clinical nurse specialist services and assistants at surgery*

(1) *Services and reimbursement for nurse practitioners and clinical nurse specialists.*—

Section 4022.—Authorizes reimbursement for services of nurse practitioners, consistent with current law on physicians' assistants, in additional settings. The services must be those which would be covered as physician services if they were performed by a physician; services performed must be within the scope of services authorized by state law to be performed by nurse practitioners. They must be performed in collaboration with a physician, which means a process in which a nurse practitioner works with a physician to deliver health care services within the scope of the nurse practitioner's expertise, with jointly developed guidelines for medical direction and appropriate supervision or other mechanisms defined by state law in the state where services are performed. Such services must be performed in a hospital, skilled nursing facility, nursing facility, as an assistant at surgery, or in a rural area which has been designated as a health manpower shortage area by the Public Health Service Act.

Reimbursement for nurse practitioner services is on the same basis as reimbursement for physicians' assistants. Payment may only be made on an assignment related basis and is

only to be paid to employers of nurse practitioners. Prevailing charges for services performed as an assistant at surgery can not exceed 65 percent of the amount that would be recognized if performed by a physician serving as an assistant at surgery. For other services provided in a hospital, excluding services performed as an assistant at surgery, reimbursement can not exceed 75 percent of the amount that would be recognized if performed by non-specialist physicians. For all other services, prevailing charges can not exceed 85 percent of the prevailing charge rate determined for services performed by non-specialist physicians.

(2) *Payment for routine visits by members of a team.—*

Section 4022.—Directs the Secretary to instruct carriers to develop mechanisms which permit routine Medicare payment for up to 1.5 team visits per month to residents of a nursing facility. Team refers to a physician and includes a physician assistant working under the supervision of the physician or a nurse practitioner working in collaboration with the physician, or both.

(3) *Reduction in payment to avoid duplicate payment.—*

Section 4022.—Authorizes the Secretary to reduce Medicare payments to hospitals and skilled nursing facilities to eliminate estimated duplicate payments for historical or current costs for nurse practitioners' services.

(4) *State demonstration projects on visit limitations.—*

Section 4022.—Directs the Secretary to provide at least one demonstration project in which the 1.5 limitation on visits by a physician and physician assistant team or a physician and nurse practitioner team would be applied on an average basis over the aggregate total of residents receiving services from members of the team, instead of on an individual basis.

(5) *GAO study of payment for services of nurse practitioners and clinical nurse specialists.—*

Section 10137.—Directs the Comptroller General to conduct a study on the feasibility of providing Medicare payment for services of nurse practitioners and clinical nurse specialists (particularly for inpatients) on the same basis as physician assistants. The study is to examine the following: (1) the licensing standards and educational requirements for nurse practitioners and clinical nurse specialists; (2) the types of services they currently provide to Medicare beneficiaries; (3) employment and compensation arrangements for these practitioners and specialists; (4) the experience and use of such practitioners and specialists in Medicare demonstration projects; and (5) the cost-effectiveness of covering these practitioners and specialists under Medicare. The report is to be submitted not later than 1 year after the date of enactment and is to include recommendations the Comptroller General deems appropriate.

(6) *Study of payments for assistants at surgery.—*

Section 10137.—Requires the Physician Payment Review Commission to conduct a study of Medicare payments for assistants at surgery. The study is to examine the necessity and appropriateness of using an assistant at surgery and the use of physician and non-physician assistants at surgery. The Com-

mission is to submit its report to Congress by May 1, 1990 with recommendations it deems appropriate.

Section 4017.—Requires the Physician Payment Review Commission to Study the appropriateness of providing for payments and the appropriate level of Medicare payments for assistants at surgery. The Commission is to submit its report to Congress by January 15, 1991, and to include recommendations it deems appropriate.

Effective date

Section 10137.—Enactment.

Section 4017.—Enactment.

Section 4022.—Applies to services furnished on or after January 1, 1990.

(c) Federally qualified health centers

(1) Inclusion of federally qualified health center services in Medicare benefits.—

Section 10136.—Includes Federally qualified health center services in the list of medical and other health services that are included in Medicare Part B benefits. Defines a federally qualified health center as a facility which is: 1) receiving a grant under Sections 329 (migrant health centers, 330 (community health centers) or 340 (health care centers for the homeless) of the Public Health Service Act; or 2) determined by the Secretary to meet the requirements for receiving a PHS grant, based on the recommendation of the Health Resources and Services Administration within the Public Health Service; or 3) was treated by the Secretary, for purposes of Medicare Part B as a comprehensive federally funded health center as of January 1, 1989. Defines federally qualified health center services as the same services provided by rural health centers eligible to participate in Medicare. Such services must be provided to an outpatient of a Federally qualified health center.

Section 4014.—Identical provision

(2) Medicare payment for federally qualified health center services.—

Section 10136.—Provides for reimbursement of Federally qualified health center services on the same basis as reimbursement for rural health center services.

Section 4014.—Identical provision

(3) Waiver of part B deductible.—

Section 10136.—Exempts beneficiaries from the requirement to pay a Medicare Part B deductible for services received at a Federally qualified health center.

Section 4014.—Identical provision

(4) Requirements governing Medicare payments in specified circumstances.—

Section 10136.—Exempts Medicare services rendered in Federally qualified health centers from the payment exclusion.

Section 4014.—Identical provision

(5) Exemption from anti-kickback requirement.—

Section 10136.—Stipulates that federally qualified health care centers who waive any Medicare Part B coinsurance for

people who qualify for subsidized services under the Public Health Service Act are exempt from the anti-kickback provision.

Section 4014.—Identical provision

Effective date

Section 10136—Applies to services furnished on or after April 1, 1990, except that Provision (c) (2) applies to a Federally qualified health center that was receiving reasonable charge reimbursement as of January 1, 1989 and that elects to receive reasonable charge reimbursement on and after a date the center elects, but not before April 1, 1990.

Section 4014—Applies to services furnished on or after January 1, 1990.

(d) Rural health clinic services

(1) Staffing requirements; inclusion of certified nurse midwife.—

*Section 4024.—*Requires a nurse practitioner, physician assistant, or nurse midwife to be available to furnish patient care services at least 50 percent of the time a clinic operates.

(2) Coverage of clinical social worker and certified nurse midwife services.—

*Section 4024.—*Adds services provided by clinical social workers to the list of services which are covered in rural health clinics.

(3) Expansion of areas eligible for rural health center status.—

*Section 4024.—*Expands the number of areas which may be qualified to have a rural health clinic in the following three ways: 1) by permitting State governors to designate areas of States as having a shortage of personal health services if the Secretary also certifies the areas as such; 2) by including areas defined as high impact areas under Section 329(a)(5) of the Public Health Service Act; and 3) by including areas with a population group which the Secretary determines has a health manpower shortage under Section 332(a)(1)(B) of the Public Health Service Act.

(4) Dissemination of rural health clinic information.—

*Section 4024.—*Directs the Secretary, in consultation with the Director of the Office of Rural Health Policy, to disseminate applications and necessary information about applying for designation as a Medicare and Medicaid rural health center within 60 days of enactment of this provision. Applications and accompanying information are to be disseminated to health care facilities and governors, chief health officers, and chief human services officers of States. Defines health care facility for the purposes of this provision as a community health center, migrant health center, home health agency, or a Medicare or Medicaid certified skilled nursing facility. Defines State for the purposes of this provision as including the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam and American Samoa.

(5) Treatment of certain facilities as rural health clinics.—

*Section 4024.—*Prohibits the Secretary from denying rural health clinic status to a facility located on an island that

would be qualified for certification except for the fact that it does not meet the requirement for the services of a physician assistant or nurse practitioner.

Effective date

Section 4024—Provisions (a), (b) and (c)—October 1, 1989; Provisions (d) and (e)—Enactment.

Senate amendment

No provision.

Conference agreement

(a) *Certified registered nurse anesthetists.*—The conference agreement includes the House provision with an amendment. The requirement providing for increasing the CRNA fee schedule is deleted. In addition, the number of surgeries required for hospital to qualify for retaining the CRNA pass-through is increased.

(b) *Nurse practitioner services and assistants at surgery.*—

(i) *Services and reimbursement for nurse practitioners and clinical nurse specialists.*—The conference agreement includes the House provision with an amendment which specifies that nurse practitioner services are reimbursable by Medicare only if they are performed in a nursing facility.

(ii) *Payment for routine visits by members of a team.*—The conference agreement includes the House provision.

(iii) *Reduction in payment to avoid duplicate payment.*—No provision.

(iv) *State demonstrations projects on visit limitations.*—The conference agreement includes the House provision.

(v) *PHYSPRC study of payments for assistance at surgery.*—The conference agreement includes section 10137 of the House provision with the requirement that the study include an assessment of the effects of section 9338 of OBRA 1986 on registered nurses as assistants in surgery. The provision requires that the commission is to submit its report to Congress by not later than April 1, 1991.

The provisions regarding nurse practitioner and clinical nurse specialists apply to services performed on or after April 1, 1990.

(c) *Federally qualified health center services.*—The conference agreement does not include the House provision.

11. Coverage of Preventive Services

Sections 10137(b) and 4023 of House bill.

Present law

(a) *Coverage of screening pap smears.*—No provision.

(b) *Modification of therapeutic shoes for individuals with severe diabetic foot disease.*—OBRA 87 authorized the Secretary to establish a demonstration program, beginning October 1, 1988, to test the cost effectiveness of furnishing therapeutic shoes to a sample group of Medicare beneficiaries who have diabetes. Included in the definition of shoes are extra-depth shoes with inserts or custom

of hospitals' costs for providing these services and the prevailing charges for providing the same services in physicians' offices.

(b) Extension of municipal health service demonstration projects

The Social Security Amendments of 1967 authorized the creation of four municipal health service demonstration projects, located in Baltimore, Cincinnati, Milwaukee, and San Jose. The Consolidated Omnibus Budget Act of 1985 (COBRA) extended the demonstrations for an additional three years.

(c) Physical and occupational therapy services

(1) Increase in limit of maximum payments.—Under current law, Medicare payments for occupational and physical therapy services rendered by a therapist in his office or in an individual's home are subject to a payment limit. Medicare only considers as incurred expenses the first \$500 in any one year. This amount is subject to Part B deductible and coinsurance requirements.

(2) GAO study of physical and occupational therapy services.—No provision.

(d) Study of reimbursement for ambulance services

Reimbursement for ambulance services is made in different ways, depending on who provides the service. It is paid under Part A if a hospital inpatient is transported from one hospital to another to receive treatment not available at the first hospital. If the hospital is paid under PPS, reimbursement is included in the PPS payment; if reimbursement to the hospital is made on a cost basis, ambulance services are also reimbursed on the basis of cost. If a hospital inpatient is transported to another hospital to be admitted, payment for the service is made under Part B. Ambulance services provided by hospitals under Part B are reimbursed on a reasonable cost basis. Ambulance services provided by independent ambulance companies are reimbursed on a reasonable charge basis, subject to an inflation index. The inflation index, which is equal to the CPI-U, serves as a limit on the lowest of the actual, customary or prevailing charge.

(e) GAO study of cost of magnetic resonance imaging

Payment for magnetic resonance imaging (MRI) varies, depending on who performs the service and the service site. Payment for MRIs performed by or under the supervision of a radiologist are reimbursed according to the radiology fee schedule. MRIs performed by or under the supervision of physicians who are not radiologists are reimbursed on the basis of reasonable charges. Payments for MRIs performed in outpatient hospital departments are subject to an aggregate limit that includes all outpatient radiology services.

The limit applies to both capital and noncapital cost and is the lesser of reasonable costs or charges or a blend of the hospital's costs and the prevailing charges for providing the same services in a physician's office. For FY 89, the limit is the sum of (1) a hospital's reasonable cost for providing the service multiplied by .65 and (2) 62 percent of the prevailing charge (minus the 20 percent coinsurance) of participating physicians for providing the same service

in their office multiplied by .35. For FY 90 and subsequent years, the split is 50 percent costs and 50 percent charges.

(f) Study of blood clotting factor for hemophilia patients

Reimbursement for blood clotting factors for hemophilia patients under Part B is made on a reasonable charge basis. Reasonable charges include charges for the factors and any supplies used for self administration. Reimbursement is based upon the least expensive medically necessary blood clotting factors. The Food and Drug Administration has determined that both non-heat treated and health treated factors are safe and effective. Therefore, unless a prescription explicitly calls for heat treated factor, reimbursement is based on the less expensive, non-heat treated factor.

(g) Study of medicaid physician fees

No provision.

House bill

(a) Coverage and payment for outpatient rural primary care hospital services under part B

Section 10137.—Defines outpatient rural primary care hospital services as medical and other health services furnished by a rural primary care hospital. Section 10102, as added by this bill, defines a rural primary care hospital as a facility designated as such by the Secretary. Permits rural primary care hospitals to choose between two payment methods for outpatient rural primary care services until 1993.

Provides that, under the first reimbursement method, payment is made for a cost-based facility fee plus professional charges. Payment for the facility fee is made on the basis of the lesser of reasonable costs or customary charges, less coinsurance, but limited to 80 percent of reasonable costs for facility services. In addition, payment is made on the basis of reasonable charges for professional medical services on the same basis as payment is made for professional medical services not rendered in outpatient rural primary care hospitals.

Provides that, under the second reimbursement method, payment is made for both facility services and professional medical services on the basis of an all-inclusive rate. The all-inclusive rate is to include reimbursement for all costs which are reasonable and related to the cost of furnishing such services or which are based on other reasonableness tests determined by the Secretary, less coinsurance and deductible payments made by beneficiaries. Payment for these services, excluding pneumococcal vaccine and influenza vaccine and their administration and for items furnished in connection with obtaining a second opinion, (or a third opinion, if the second opinion differed from the first), is limited to 80 percent of reasonable costs.

Directs the Secretary to develop and implement a prospective payment system for outpatient rural hospital primary care services by January 1, 1993. The reimbursement system is to be based on a methodology that includes all costs in providing outpatient rural

primary care services, including professional medical services and determine payment on a prospective basis.

Effective date

Enactment.

(b) Extension of municipal health service demonstration projects

Section 10137.—Extends the municipal health service demonstration projects through December 31, 1993. The Secretary is required to submit a report to Congress on the program with respect to quality of health care, beneficiary costs, and other appropriate factors.

Effective date

Enactment.

(c) Physical and occupational therapy services

(1) Increase in limit of maximum payments.—

Section 4015.—Increases the limit on recognized expenses for physical and occupational therapy services from \$500 to \$750 a year.

(2) GAO study of physical and occupational therapy services.—

Section 4015.—Directs the Comptroller General to conduct a study of the provision of physical and occupational therapy services under Medicare. The study is to include an examination of the availability of services in different settings and the appropriateness of current payment methods. The report is due to the House Committees on Energy and Commerce and Ways and Means and the Senate Finance Committee by January 15, 1991, and is to include appropriate recommendations from the Comptroller General.

Effective date

Section 4015—(1)—Applies beginning with 1990; (2)—Enactment.

(d) Study of reimbursement for ambulance services

Section 10137.—Requires the Secretary to conduct a study to determine the adequacy and appropriateness of Medicare payments for ambulance services. The study is to examine the following: 1) the effect of payment amount on the provision of ambulance services in rural areas; 2) the relationship of Medicare payment amounts to the direct and indirect costs of providing ambulance services, including a separate examination of the relationship for the following: a) tax-subsidized, municipally owned and operated services; b) volunteer services; c) private, for-profit services; d) hospital-owned services and e) different levels (such as basic life support and advanced life support) of such services; and 3) how Medicare payments compare to payment amounts made under state Medicaid plans for ambulance services.

Requires the Secretary to submit his report not later than one year after this provision is enacted, including recommendations for changes in Medicare payment policies for ambulance services needed to ensure access to quality ambulance services in metropolitan and rural areas.

Section 4016.—Identical provision.

Effective date

Enactment.

(e) GAO study of cost of magnetic resonance imaging

Section 10137.—Directs the Comptroller General to conduct a study comparing Medicare payment amounts and costs for magnetic resonance imaging (MRI). The study is to be submitted to Congress by July 1, 1990, with recommendations deemed appropriate by the Comptroller General.

Effective date

Enactment.

(f) Study of blood clotting factor for hemophilia patients

Section 4018.—Directs the Secretary to review the current methodology for reimbursing for blood clotting factor for hemophilia patients under Medicare Part B and to evaluate the effect of the methodology on the accessibility and affordability of the factor to Medicare beneficiaries. The Secretary is to report his finding to the House Committees on Energy and Commerce and Ways and Means and the Senate Finance Committee no later than 6 months after the date of enactment of this provision. The report is to contain recommendations deemed appropriate by the Secretary.

Effective date

Enactment.

(g) Study of medicaid physician fees

Section 4026.—Requires the Physician Payment Review Commission to review the adequacy and appropriateness of payment rates for physicians' services under State Medicaid plans.

Effective date

Section 4026—Enactment.

Senate amendment

No provision.

Conference agreement

(a) Coverage and payment for outpatient rural primary care hospital services under part B.—The conference agreement includes the House provisions.

(b) Extension of municipal health service demonstration projects.—The conference agreement includes the House provision.

(c) Physical and occupational therapy services.—The conference agreement includes the House provision with an amendment to strike the GAO study.

(d) Study of reimbursement for ambulance services.—The conference agreement includes the House provision.

(e) GAO study of cost of magnetic resonance imaging.—The conference agreement does not include the House provision.

(f) *Study of reimbursement for blood clotting factor for hemophilia patients.*—The conference agreement includes the House provision.

(g) *Physician Payment Review Commission study of Medicaid physician fees.*—The conference agreement does not include the House provision.

TABLE 1.—PRACTICE EXPENSE RATIOS

Code and description		Practice expense ratio
Group A: Procedure codes:		
19162	Remove breast tissue: Nodes.....	52
19200	Extensive breast surgery	53
19220	Extensive breast surgery	52
19240	Extensive breast surgery	51
27125	Revise hip with prosthesis.....	61
27126	Revise hip with prosthesis.....	60
27127	Revise hip with prosthesis.....	62
27130	Total hip joint replacement.....	61
27132	Total hip joint replacement.....	63
27134	Revise hip joint replacement	59
27137	Revise hip joint component	57
27138	Revise hip joint component	56
28290	Correction of bunion	62
28292	Correction of bunion	63
28293	Correction of bunion	63
28294	Correction of bunion	63
28296	Correction of bunion	61
28297	Correction of bunion	66
28298	Correction of bunion	63
28299	Correction of bunion	65
29870	Knee arthroscopy.....	62
29871	Knee arthroscopy/drainage.....	62
29872	Knee arthroscopy/drainage.....	64
29874	Knee arthroscopy/surgery.....	68
29875	Knee arthroscopy/surgery.....	68
29876	Knee arthroscopy/surgery.....	67
29877	Knee arthroscopy/surgery.....	75
29879	Knee arthroscopy/surgery.....	69
29880	Knee arthroscopy/surgery.....	73
29881	Knee arthroscopy/surgery.....	69
29882	Knee arthroscopy/surgery.....	66
29884	Knee arthroscopy/surgery.....	64
29886	Knee arthroscopy/surgery.....	68
29887	Knee arthroscopy/surgery.....	67
29889	Knee arthroscopy/surgery.....	59
31000	Irrigation maxillary sinus.....	62
31001	Irrigation maxillary sinuses.....	66
31002	Irrigation sphenoid sinus	55
31020	Exploration maxillary sinus.....	56
31021	Exploration of sinuses.....	59
31030	Exploration maxillary sinus.....	61
31031	Exploration of sinuses.....	61
31032	Explore sinus: remove polyps.....	60
31033	Enter sinus: remove polyps.....	61
31360	Removal of larynx	54
31365	Removal of larynx	55
31367	Partial removal of larynx.....	54
31368	Partial removal of larynx.....	52
32440	Removal of lung	53
32480	Partial removal of lung.....	53
32500	Partial removal of lung.....	53
32520	Remove lung and revise chest	53

TABLE 1.—PRACTICE EXPENSE RATIOS—Continued

Code and description		Practice expense ratio
32522	Remove lung and revise chest	52
32525	Remove lung and revise chest	53
33206	Insertion of heart pacemaker.....	71
33207	Insertion of heart pacemaker.....	69
33208	Insertion of heart pacemaker.....	69
33210	Insertion of heart electrode	70
33212	Insertion of pulse generator	69
33216	Revision implanted electrode	66
33218	Repair pacemaker electrodes	66
33219	Repair of pacemaker	66
33232	Removal of pacemaker	62
33405	Replacement of aortic valve	62
33510	Coronary artery bypass.....	66
33511	Coronary arteries bypass	65
33512	Coronary arteries bypass	65
33513	Coronary arteries bypass	64
33514	Coronary arteries bypass	64
33516	Coronary arteries bypass	65
35001	Repair defect of artery	53
35011	Repair defect of artery	53
35013	Repair artery rupture, arm	52
35021	Repair defect of artery	52
35045	Repair defect of arm artery.....	54
35081	Repair defect of artery	55
35082	Repair artery rupture: aorta	57
35091	Repair defect of artery	53
35092	Repair artery rupture, belly	54
35102	Repair defect of artery	54
35103	Repair artery rupture: groin.....	55
35112	Repair artery rupture, spleen.....	58
35121	Repair defect of artery	53
35122	Repair artery rupture, belly	59
35131	Repair defect of artery	52
35132	Repair artery rupture, groin.....	54
35141	Repair defect of artery	55
35142	Repair artery rupture, thigh.....	53
35151	Repair defect of artery	53
35152	Repair artery rupture, knee	53
35161	Repair defect of artery	55
35301	Rechanneling of artery	61
35311	Rechanneling of artery	62
35321	Rechanneling of artery	58
35331	Rechanneling of artery	58
35341	Rechanneling of artery	58
35351	Rechanneling of artery	59
35355	Rechanneling of artery	60
35361	Rechanneling of artery	61
35363	Rechanneling of artery	61
35371	Rechanneling of artery	62
35372	Rechanneling of artery	62
35381	Rechanneling of artery	59
39400	Visualization of mediastinum	53
44120	Removal of small intestine	51
44130	Bowel to bowel fusion.....	51
44140	Partial removal of colon	52
44141	Partial removal of colon	51
44143	Partial removal of colon	52
44144	Partial removal of colon	51
44145	Partial removal of colon	51
44146	Partial removal of colon	53
44147	Partial removal of colon	50
44150	Removal of colon.....	53

TABLE 1.—PRACTICE EXPENSE RATIOS—Continued

Code and description		Practice expense ratio
44152	Removal of colon/ileostomy	53
44153	Removal of colon/ileostomy	54
44155	Removal of colon.....	51
44156	Removal of colon/ileostomy	56
44160	Removal of colon.....	53
44950	Appendectomy	55
44960	Appendectomy	54
45378	Diagnostic colonoscopy.....	66
45379	Colonoscopy.....	64
45380	Colonoscopy and biopsy.....	66
45382	Colonoscopy, control bleeding.....	65
45383	Colonoscopy, lesion removal	65
45385	Colonoscopy, lesion removal	76
47600	Removal of gallbladder	56
47605	Removal of gallbladder	55
47610	Removal of gallbladder	54
47620	Removal of gallbladder	54
49500	Repair inguinal hernia.....	60
44905	Repair inguinal hernia.....	63
49510	Repair hernia: remove testis.....	62
49515	Repair inguinal hernia.....	61
49520	Rerepair inguinal hernia.....	63
49525	Repair inguinal hernia.....	65
49530	Repair incarcerated hernia.....	62
49535	Repair strangulated hernia.....	60
49540	Repair lumbar hernia.....	61
49550	Repair femoral hernia	63
49552	Repair femoral hernia	59
49555	Repair femoral hernia	61
49560	Repair abdominal hernia.....	63
49565	Rerepair abdominal hernia.....	62
49570	Repair epigastric hernia.....	60
49575	Repair epigastric hernia.....	59
49580	Repair umbilical hernia.....	60
49581	Repair umbilical hernia.....	63
49590	Repair abdominal hernia.....	62
50590	Fragmenting of kidney stone.....	51
52500	Revision of bladder neck	53
52601	Prostatectomy, (tur).....	52
52612	Prostatectomy, first stage.....	47
52614	Prostatectomy, second stage.....	48
52630	Remove prostate regrowth.....	52
42640	Relieve bladder constricture.....	51
52650	Prostatectomy.....	56
58102	Curettage of uterus lining	58
58150	Total hysterectomy.....	61
58152	Total hysterectomy.....	60
58180	Partial hysterectomy.....	57
58200	Extensive hysterectomy	62
58210	Extensive hysterectomy	61
58260	Vaginal hysterectomy.....	64
58265	Hysterectomy and vagina repair	61
58267	Hysterectomy and vagina repair	64
58270	Hysterectomy and vagina repair	62
58275	Hysterectomy, revise vagina.....	57
58280	Hysterectomy, revise vagina.....	59
58285	Extensive hysterectomy	61
63001	Removal of spinal lamina	55
63003	Removal of spinal lamina	56
63005	Removal of spinal lamina	56
63010	Removal of spinal lamina	58
63015	Removal of spinal lamina	57

TABLE 1.—PRACTICE EXPENSE RATIOS—Continued

Code and description		Practice expense ratio
63016	Removal of spinal lamina	56
63017	Removal of spinal lamina	57
63030	Low back disk surgery	54
63031	Low back disk surgery	57
63935	Added spinal disk surgery	49
64716	Revision of cranial nerve	68
64718	Revise ulnar nerve at elbow	65
64719	Revise ulnar nerve at wrist	66
64721	Revise median nerve at wrist	67
65850	Incision of eye	65
65855	Laser surgery of eye	65
66840	Removal of lens material	52
66850	Removal of lens material	61
66920	Extraction of lens	59
66930	Extraction of lens	51
66940	Extraction of lens	55
66983	Remove cataract: insert lens	61
66984	Remove cataract: insert lens	59
66985	Insert lens prosthesis	58
67107	Repair detached retina	59
67108	Repair detached retina	59
67208	Treatment of retinal lesion	63
67210	Treatment of retinal lesion	64
67218	Treatment of retinal lesion	59
67227	Treatment of retinal lesion	62
67228	Treatment of retinal lesion	63
69631	Repair eardrum structures	54
69632	Rebuild eardrum structures	52
69633	Rebuild eardrum structures	51
69635	Repair eardrum structures	53
69636	Rebuild eardrum structures	51
69637	Rebuild eardrum structures	57
69641	Revise middle ear and mastoid	53
69642	Revise middle ear and mastoid	51
69644	Revise middle ear and mastoid	53
69646	Revise middle ear and mastoid	54
76700	Echo exam of abdomen	58
76705	Echo exam of abdomen	55
76770	Echo exam of abdomen	58
76775	Echo exam abdomen back wall	57
92226	Extended ophthalmoscopy	58
92230	Ophthalmoscopy/angiography	57
92235	Ophthalmoscopy/angiography	56
92265	Eye muscle evaluation	76
92270	Electro-oculography	77
92275	Electroretinography	79
92280	Special eye evaluation	79
92283	Color vision examination	75
92284	Dark adaptation eye exam	80
92285	Eye photography	78
92286	Internal eye photography	77
92287	Internal eye photography	82
93000	Electrocardiogram: complete	66
93005	Electrocardiogram: tracing	66
93010	Electrocardiogram report	61
93012	Transmission of ECG	65
93014	Report on transmitted ECG	61
93015	Cardiovascular stress test	65
93017	Cardiovascular stress test	61
93018	Cardiovascular stress test	60
93024	Cardiac drug stress test	58
93040	Rhythm ECG with report	61

TABLE 1.—PRACTICE EXPENSE RATIOS—Continued

Code and description		Practice expense ratio
93041	Rhythm ECG, tracing.....	58
93042	Rhythm ECG: report.....	54
93045	Special ECG.....	64
93501	Right heart catheterization.....	64
93503	Right heart catheterization.....	65
93505	Biopsy of heart lining.....	63

TABLE 2.—OVERVALUED PROCEDURES

Code and description		One-third of difference
19162	Remove breast tissue: Nodes.....	—3
19200	Extensive breast surgery	—5
19220	Extensive breast surgery	—4
19240	Extensive breast surgery	—4
27125	Revise hip with prosthesis.....	—6
27126	Revise hip with prosthesis.....	—5
27127	Revise hip with prosthesis.....	—6
27130	Total hip joint replacement.....	—6
27132	Total hip joint replacement.....	—4
27134	Revise hip joint replacement	—6
27137	Revise hip joint component	—5
27138	Revise hip joint component	—5
28290	Correction of bunion.....	—4
28292	Correction of bunion.....	—7
28293	Correction of bunion.....	—4
28294	Correction of bunion.....	—4
28296	Correction of bunion.....	—6
28297	Correction of bunion.....	—5
28298	Correction of bunion.....	—4
28299	Correction of bunion.....	—5
29870	Knee arthroscopy.....	—9
29871	Knee arthroscopy/drainage.....	—9
29872	Knee arthroscopy/drainage.....	—9
29874	Knee arthroscopy/surgery.....	—11
29875	Knee arthroscopy/surgery.....	—8
29876	Knee arthroscopy/surgery.....	—10
29877	Knee arthroscopy/surgery.....	—11
29879	Knee arthroscopy/surgery.....	—11
29880	Knee arthroscopy/surgery.....	—12
29881	Knee arthroscopy/surgery.....	—9
29882	Knee arthroscopy/surgery.....	—10
29884	Knee arthroscopy/surgery.....	—9
29886	Knee arthroscopy/surgery.....	—11
29887	Knee arthroscopy/surgery.....	—10
29889	Knee arthroscopy/surgery.....	—7
31000	Irrigation maxillary sinus.....	—6
31001	Irrigation maxillary sinuses.....	—6
31002	Irrigation sphenoid sinus.....	—5
31020	Exploration maxillary sinus.....	—6
31021	Exploration of sinuses.....	—8
31030	Exploration maxillary sinus.....	—8
31031	Exploration of sinuses.....	—8
31032	Explore sinus: Remove polyps.....	—7
30133	Enter sinuses, remove polyps	—8
31360	Removal of larynx.....	—4
31365	Removal of larynx.....	—5
31367	Partial removal of larynx.....	—5
31368	Partial removal of larynx.....	—3

TABLE 2.—OVERVALUED PROCEDURES—Continued

Code and description		One-third of difference
32440	Removal of lung	-4
32480	Partial removal of lung.....	-4
32500	Partial removal of lung.....	-4
32520	Remove lung and revise chest.....	-4
32522	Remove lung and revise chest.....	-3
32525	Remove lung and revise chest.....	-4
33206	Insertion of heart pacemaker.....	-11
33207	Insertion of heart pacemaker.....	-12
33208	Insertion of heart pacemaker.....	-11
33210	Insertion of heart electrode	-13
33212	Insertion of pulse generator.....	-11
33216	Revision implanted electrode	-13
33218	Repair pacemaker electrodes	-13
33219	Repair of pacemaker.....	-12
33232	Removal of pacemaker	-11
33405	Replacement of aortic valve	-8
33510	Coronary artery bypass.....	-8
33511	Coronary arteries bypass	-8
33512	Coronary arteries bypass	-9
33513	Coronary arteries bypass	-9
33514	Coronary arteries bypass	-9
33516	Coronary arteries bypass	-10
35001	Repair defect of artery	-4
35011	Repair defect of artery	-4
35013	Repair artery rupture, arm	-3
35021	Repair defect of artery	-4
35045	Repair defect of arm artery.....	-5
35081	Repair defect of artery	-6
35082	Repair artery rupture: Aorta	-6
35091	Repair defect of artery	-6
35092	Repair artery rupture, belly	-5
35102	Repair defect of artery	-5
35103	Repair artery rupture: Groin	-6
35112	Repair artery rupture, spleen.....	-7
35121	Repair defect of artery	-4
35122	Repair artery rupture, belly	-7
35131	Repair defect of artery	-3
35132	Repair artery rupture, groin.....	-5
35141	Repair defect of artery	-5
35142	Repair artery rupture, thigh.....	-4
35151	Repair defect of artery	-4
35152	Repair artery rupture, knee	-4
35161	Repair defect of artery	-5
35301	Rechanneling of artery	-9
35311	Rechanneling of artery	-8
35321	Rechanneling of artery	-7
35331	Rechanneling of artery	-7
35341	Rechanneling of artery	-7
35351	Rechanneling of artery	-7
35355	Rechanneling of artery	-7
35361	Rechanneling of artery	-8
35363	Rechanneling of artery	-8
35371	Rechanneling of artery	-9
35372	Rechanneling of artery	-9
35381	Rechanneling of artery	-7
39400	Visualization of mediastinum	-4
44120	Removal of small intestine	-4
44130	Bowel to bowel fusion.....	-4
44140	Partial removal of colon	-5
44141	Partial removal of colon	-4
44143	Partial removal of colon	-4
44144	Partial removal of colon	-4

TABLE 2.—OVERVALUED PROCEDURES—Continued

Code and description		One-third of difference
44145	Partial removal of colon	-4
44146	Partial removal of colon	-5
44147	Partial removal of colon	-3
44150	Removal of colon	-5
44152	Removal of colon/ileostomy	-5
44153	Removal of colon/ileostomy	-6
44155	Removal of colon	-4
44156	Removal of colon/ileostomy	-7
44160	Removal of colon	-5
44950	Appendectomy	-7
44960	Appendectomy	-6
45378	Diagnostic colonoscopy	-9
45379	Colonoscopy	-8
45380	Colonoscopy and biopsy	-9
45382	Colonoscopy, control bleeding	-8
45383	Colonoscopy, lesion removal	-8
45385	Colonoscopy: Lesion removal	-10
47600	Removal of gallbladder	-7
47605	Removal of gallbladder	-7
47610	Removal of gallbladder	-6
47620	Removal of gallbladder	-6
49500	Repair inguinal hernia	-7
49505	Repair inguinal hernia	-9
49510	Repair hernia: Remove testis	-10
49515	Repair inguinal hernia	-8
49520	Repair inguinal hernia	-9
49525	Repair inguinal hernia	-9
49530	Repair incarcerated hernia	-9
49535	Repair strangulated hernia	-7
49540	Repair lumbar hernia	-7
49550	Repair femoral hernia	-9
49552	Repair femoral hernia	-7
49555	Remove femoral hernia	-7
49560	Repair abdominal hernia	-10
49565	Repair abdominal hernia	-10
49570	Repair epigastric hernia	-7
49575	Repair epigastric hernia	-7
49580	Repair umbilical hernia	-7
49581	Repair umbilical hernia	-10
49590	Repair abdominal hernia	-8
50590	Fragmenting of kidney stone	-5
52500	Revision of bladder neck	-5
52601	Prostatectomy (TUR)	-6
52612	Prostatectomy, first stage	-4
52614	Prostatectomy, second stage	-4
52630	Remove prostate regrowth	-5
52640	Relieve bladder constricture	-6
52650	Prostatectomy	-8
58102	Curettage of uterus lining	-5
58120	Dilation and curettage	-4
58150	Total hysterectomy	-7
58152	Total hysterectomy	-7
58180	Partial hysterectomy	-4
58200	Extensive hysterectomy	-6
58210	Extensive hysterectomy	-6
58260	Vaginal hysterectomy	-7
58265	Hysterectomy and vagina repair	-7
58267	Hysterectomy and vagina repair	-8
58270	Hysterectomy and vagina repair	-7
58275	Hysterectomy, revise vagina	-5
58280	Hysterectomy, revise vagina	-6
58285	Extensive hysterectomy	-7

TABLE 2.—OVERVALUED PROCEDURES—Continued

Code and description		One-third of difference
63001	Removal of spinal lamina.....	-5
63003	Removal of spinal lamina.....	-3
63005	Removal of spinal lamina.....	-5
63010	Removal of spinal lamina.....	-7
63015	Removal of spinal lamina.....	-6
63016	Removal of spinal lamina.....	-5
63017	Removal of spinal lamina.....	-5
63030	Low back disk surgery.....	-5
63031	Low back disk surgery.....	-5
63035	Added spinal disk surgery.....	-3
64716	Revision of cranial nerve.....	-10
64718	Revise ulnar nerve at elbow.....	-9
64719	Revise ulnar nerve at wrist.....	-9
64721	Revise median nerve at wrist.....	-9
65850	Incision of eye.....	-8
65855	Laser surgery of eye.....	-8
66840	Removal of lens material.....	-5
66850	Removal of lens material.....	-4
66920	Extraction of lens.....	-6
66930	Extraction of lens.....	-5
66940	Extraction of lens.....	-4
66983	Remove cataract: Insert lens.....	-6
66984	Remove cataract: Insert lens.....	-6
66985	Insert lens prosthesis.....	-5
67107	Repair detached retina.....	-6
67108	Repair detached retina.....	-6
67208	Treatment of retinal lesion.....	-7
67210	Treatment of retinal lesion.....	-8
67218	Treatment of retinal lesion.....	-5
67227	Treatment of retinal lesion.....	-7
67228	Treatment of retinal lesion.....	-7
69631	Repair eardrum structures.....	-5
69632	Rebuild eardrum structures.....	-3
69633	Rebuild eardrum structures.....	-3
69635	Repair eardrum structures.....	-4
69636	Rebuild eardrum structures.....	-3
69637	Rebuild eardrum structures.....	-5
69641	Revise middle ear and mastoid.....	-4
69642	Revise middle ear and mastoid.....	-4
69644	Revise middle ear and mastoid.....	-3
69646	Revise middle ear and mastoid.....	-3
76700	Echo exam of abdomen.....	-7
76705	Echo exam of abdomen.....	-11
76770	Echo exam of abdomen.....	-7
76775	Echo exam abdomen back wall.....	-9
92226	Extended ophthalmoscopy.....	-4
92230	Ophthalmoscopy/angiography.....	-3
92235	Ophthalmoscopy/angiography.....	-4
92265	Eye muscle evaluation.....	-11
92270	Electro-oculography.....	-11
92275	Electroretinography.....	-12
92280	Special eye evaluation.....	-12
92283	Color vision examination.....	-10
92284	Dark adaptation eye exam.....	-12
92285	Eye photography.....	-11
92286	Internal eye photography.....	-11
92287	Internal eye photography.....	-12
93000	Electrocardiogram: Complete.....	-9
93005	Electrocardiogram: Tracing.....	-8
93010	Electrocardiogram report.....	-9
93012	Transmission of ECG.....	-9
93014	Report on transmitted ECG.....	-7

TABLE 2.—OVERVALUED PROCEDURES—Continued

Code and description		One-third of difference
93015	Cardiovascular stress test.....	—9
93017	Cardiovascular stress test.....	—8
93018	Cardiovascular stress test.....	—9
93024	Cardiac drug stress test.....	—6
93040	Rhythm ECG with report.....	—7
93041	Rhythm ECG, tracing.....	—6
93042	Rhythm ECG: Report.....	—4
93045	Special ECG.....	—9
93501	Right heart catheterization.....	—10
93503	Right heart catheterization.....	—10
93505	Biopsy of heart lining.....	—8

TABLE 3.—LIST OF GEOGRAPHIC PRACTICE COSTS ADJUSTMENT FACTORS

Carrier locality code	Name	Overhead only
51005	Birmingham, AL.....	0.903
51004	Mobile, AL.....	0.900
51002	North Central AL.....	0.862
51001	Northwest AL.....	0.864
51006	Rural AL.....	0.848
51003	Southeast AL.....	0.862
102001	Alaska.....	1.229
103005	Flagstaff (city), AZ.....	0.953
103001	Phoenix (city), AZ.....	1.045
103007	Prescott (city), AZ.....	0.953
103099	Rural Arizona.....	0.981
103002	Tuscon (city), AZ.....	1.022
103008	Yuma (city), AZ.....	0.953
52013	Arkansas.....	0.789
205026	Anaheim-Santa Ana, CA.....	1.234
54214	Bakersfield, CA.....	1.089
54211	Fresno/Madera, CA.....	1.054
54213	Kings/Tulare, CA.....	1.046
205018	Los Angeles, CA (1st of 8).....	1.218
205019	Los Angeles, CA (2nd of 8).....	1.218
205020	Los Angeles, CA (3rd of 8).....	1.218
205021	Los Angeles, CA (4th of 8).....	1.218
205022	Los Angeles, CA (5th of 8).....	1.218
205023	Los Angeles, CA (6th of 8).....	1.218
205024	Los Angeles, CA (7th of 8).....	1.218
205025	Los Angeles, CA (8th of 8).....	1.218
54203	Marin/Napa/Solano, CA.....	1.219
54210	Merced/surrounding counties, CA.....	1.053
54212	Monterey/Santa Cruz, CA.....	1.140
54201	N. Coastal counties, CA.....	1.109
54202	NE rural CA.....	1.037
54207	Oakland-Berkeley, CA.....	1.272
54227	Riverside, CA.....	1.116
54204	Sacramento/surrounding counties, CA.....	1.123
54215	San Bernadino/E. Central CA.....	1.114
205028	San Diego/Imperial, CA.....	1.125
54205	San Francisco, CA.....	1.311
54206	San Mateo, CA.....	1.311
205016	Santa Barbara, CA.....	1.110
54209	Santa Clara, CA.....	1.294
54208	Stockton/surrounding counties, CA.....	1.070
505017	Ventura, CA.....	1.161

TABLE 3.—LIST OF GEOGRAPHIC PRACTICE COSTS ADJUSTMENT FACTORS—Continued

Carrier locality code	Name	Overhead only
55001	Colorado	0.951
307004	Eastern Connecticut	1.054
307001	NW and N. Central Connecticut	1.066
307003	South Central Connecticut	1.113
307002	SW Connecticut	1.151
57001	Delaware	0.975
58001	DC plus MD/VA suburbs	1.138
59003	Fort Lauderdale, FL	1.030
59004	Miami, FL	1.100
59002	N/NC Florida cities	0.954
59001	Rural Florida	0.900
1311001	Atlanta, GA	0.990
1311004	Rural Georgia	0.830
1311002	Small GA cities 02	0.878
1311003	Small GA cities 03	0.851
112001	Hawaii	1.086
513000	Idaho Statewide	0.927
513012	North Idaho	0.913
513011	South Idaho	0.940
62110	Champagne-Urbana, IL	0.947
62116	Chicago, IL	1.195
62103	De Kalb, IL	0.951
62111	Decatur, IL	0.953
62112	East St. Louis, IL	1.008
62106	Kankakee, IL	0.951
62108	Normal, IL	0.989
62101	Northwest, IL	0.926
62105	Peoria, IL	1.044
62107	Quincy, IL	0.926
62104	Rock Island, IL	0.943
62102	Rockford, IL	1.060
62113	Southeast, IL	0.926
62114	Southern, IL	0.926
62109	Springfield, IL	0.987
62115	Suburban Chicago, IL	1.132
63001	Metropolitan Indiana	0.913
63003	Rural Indiana	0.851
63002	Urban Indiana	0.859
64005	Des Moines (Polk/Warren), IA	0.929
64008	Iowa City (city limits), IA	0.930
64003	Northcentral Iowa	0.886
64002	Northeast Iowa	0.887
64006	Northwest Iowa	0.862
64004	S. Central IA (excluding Des Moines)	0.855
64001	SE Iowa (excluding Iowa City)	0.897
64007	Southwest Iowa	0.865
74005	Kansas City, KA	0.990
65001	Rural Kansas	0.879
74004	Suburban Kansas City, KA	0.990
66001	Lexington and Louisville, KY	0.886
66003	Rural Kentucky	0.851
66002	Sm Cities (city limits) KY	0.875
52807	Alexandria, LA	0.879
52803	Baton Rouge, LA	0.947
52806	Lafayette, LA	0.913
52804	Lake Charles, LA	0.895
52805	Monroe, LA	0.871
52801	New Orleans, LA	1.025
52850	Rural Louisiana	0.877
52802	Shreveport, LA	0.924
2120002	Central Maine	0.880

TABLE 3.—LIST OF GEOGRAPHIC PRACTICE COSTS ADJUSTMENT FACTORS—Continued

Carrier locality code	Name	Overhead only
2120001	Northern Maine	0.889
2120003	Southern Maine	0.948
69001	Baltimore/surrounding counties, MD	1.032
69003	South plus Eastern Shore, MD	0.990
69002	Western Maryland	0.996
70002	Massachusetts suburbs/rural (cities)	1.046
70001	Massachusetts urban	1.098
71001	Detroit, MI	1.170
71002	Michigan, not Detroit	1.006
72000	Minnesota carrierwide	0.920
72002	Northern Minnesota	0.898
72004	Southern Minnesota	0.883
1024001	St. Paul Minneapolis, MN	0.990
1025001	Rural Mississippi	0.814
1025002	Urban MS (city limits)	0.871
74003	KC (Jackson County), MO	0.990
74002	NKC (Clay/Platte), MO	0.990
1126003	Rural (excluding rural NW), MO	0.889
74006	Rural NW counties, MO	0.904
1126002	SM. E. cities plus (Jefferson County), MO	0.955
74001	St. Joseph, MO	0.906
1126001	St. Louis/large eastern cities, MO	1.015
75101	Montana	0.901
64500	Nebraska	0.801
64501	Omaha plus Lincoln, NE	0.869
64504	Rural Nebraska	0.800
64503	Urban (county population 25,000), NE	0.813
129003	Elko and Ely (cities), NV	1.041
129001	Las Vegas, et al. (cities), NV	1.090
129002	Reno et al. (cities), NV	1.142
129099	Rural Nevada NV	1.087
78040	New Hampshire	0.961
1331002	Middle New Jersey	1.098
1331001	Northern New Jersey	1.134
1331003	Southern New Jersey	1.084
532001	New Mexico	0.906
80101	Buffalo/surrounding counties, NY	0.945
80301	Manhattan, NY	1.330
80103	N. Central cities, NY	0.953
80302	NYC suburbs/Long Island, NY	1.318
80303	Poughkeepsie/N. NYC suburbs	1.043
1433004	Queens; NY	1.330
80102	Rochester/surrounding counties, NY	1.011
80104	Rural New York	0.939
1334095	Rural North Carolina	0.821
1334094	Urban (city limits) NC	0.859
1334000	North Carolina carrierwide	0.827
82001	North Dakota	0.870
1636001	Akron, OH	0.941
1636002	Cincinnati, OH	0.952
1636003	Cleveland, OH	0.963
1636004	Columbus, OH	0.952
1636005	Dayton, OH	0.934
1636009	E. Central (Steubenville), OH	0.914
1636007	Mansfield, OH	0.908
1636013	Marion plus surrounding counties, OH	0.913
1636006	Northwest (Lima), OH	0.920
1636014	Scioto Valley, OH	0.934
1636015	Southeast (Ohio Valley), OH	0.902
1636008	Springfield, OH	0.938
1636012	W. Central (Lake Plains), OH	0.408

TABLE 3.—LIST OF GEOGRAPHIC PRACTICE COSTS ADJUSTMENT FACTORS—Continued

Carrier locality code	Name	Overhead only
1636011	Youngstown, OH	0.935
137001	OK City, et al. (cities), OK.....	0.907
137099	Rural Oklahoma OK.....	0.833
137004	Small cities (Northern), OK.....	0.830
137003	Small cities (Southern), OK.....	0.823
137002	Tulsa, et al. (cities), OK.....	0.900
138002	Eugene, et al. (cities), OR.....	1.002
138001	Portland, et al. (cities), OR.....	1.023
138099	Rural Oregon.....	0.991
138003	Salem, et al. (cities), OR.....	0.986
138012	SW OR. cities (city limits).....	0.983
86502	Large Pennsylvania cities.....	1.045
86501	Philly/Pittsburgh Medical Schools/Hospitals.....	1.070
86504	Rural Pennsylvania.....	0.934
86503	Small Pennsylvania cities.....	0.942
87001	Rhode Island.....	0.966
88001	South Carolina.....	0.822
82002	South Dakota.....	0.836
544035	Tennessee.....	0.836
90029	Abilene, TX.....	0.833
90026	Amarillo, TX.....	0.852
90031	Austin, TX.....	0.911
90020	Beaumont, TX.....	0.900
90009	Brazoria, TX.....	0.900
90010	Brownsville, TX.....	0.842
90024	Corpus Christi, TX.....	0.891
90011	Dallas, TX.....	0.914
90012	Denton, TX.....	0.914
90014	El Paso, TX.....	0.847
90028	Fort Worth, TX.....	0.883
90015	Galveston, TX.....	0.912
90016	Grayson, TX.....	0.854
90018	Houston, TX.....	0.942
90033	Laredo, TX.....	0.813
90017	Longview, TX.....	0.878
90021	Lubbock, TX.....	0.835
90019	McAllen, TX.....	0.828
90023	Midland, TX.....	0.938
90002	Northeast Rural Texas.....	0.833
90013	Odessa, TX.....	0.914
90025	Orange, TX.....	0.900
90030	San Angelo, TX.....	0.854
90007	San Antonio, TX.....	0.817
90003	Southeast Rural Texas.....	0.845
90006	Temple, TX.....	0.840
90008	Texarkana, TX.....	0.837
90027	Tyler, TX.....	0.879
90032	Victoria, TX.....	0.916
90022	Waco, TX.....	0.826
90004	Western Rural Texas.....	0.803
90034	Wichita Falls, TX.....	0.849
91001	Utah.....	0.926
78050	Vermont.....	0.891
1049001	Richmond plus Charlottesville, VA.....	0.893
1049004	Rural Virginia.....	0.843
1049003	Small town/industrial VA.....	0.849
1049002	Tidewater plus N. VA counties.....	0.959
93004	E. Central plus (excluding Spokane).....	0.989
93002	Seattle (King County), WA.....	1.051
93003	Spokane plus Richland (cities), WA.....	1.006
93001	W plus SEWA (excluding Seattle).....	1.001

TABLE 3.—LIST OF GEOGRAPHIC PRACTICE COSTS ADJUSTMENT FACTORS—Continued

Carrier locality code	Name	Overhead only
1651016	Charlestown, WV.....	0.929
1651018	Eastern Valley, WV.....	0.961
1651019	Ohio River Valley, WV.....	0.858
1651020	Southern Valley, WV.....	0.853
1651017	Wheeling, WV.....	0.880
95113	Central Wisconsin.....	0.857
95140	Green Bay, WI (Northeast).....	0.879
95154	Janesville, WI (S-Central).....	0.872
95119	Lacrosse, WI (W-Central).....	0.889
95115	Madison, WI (Dane County).....	0.937
95146	Milwaukee suburbs, WI (SE).....	0.962
95104	Milwaukee, WI.....	0.964
95112	Northwest Wisconsin.....	0.868
95160	Oshkosh, WI (E-Central).....	0.878
95114	Southern Wisconsin.....	0.857
95136	Wausau, WI (N-Central).....	0.866
553002	Wyoming.....	0.902

PART C—PROVISIONS RELATING TO PARTS A AND B OF MEDICARE

1. Delay in Payments in Fiscal Year 1990

Section 10151 of the House bill, section 5301 of the Senate amendment.

Present law

Provider's claims for services to Medicare beneficiaries received in FY 1989 may not be paid by Federal intermediaries or carriers before a period of 14 days has expired following receipt. In addition, 95% of all clean claims (those without missing information or otherwise requiring special handling) from providers must be paid within 25 calendar days in FY 1989 and within 24 days in FY 1990. Claims by participating physicians must be paid within 18 days in FY 1989 and 17 days in FY 1990.

House bill

Requires that provider's claims not be paid before a period of 16 days has expired following receipt in FY 1990. Requires that 95% of clean claims submitted by providers be paid within 26 days of receipt, and within 21 days of receipt for participating physicians

Effective date

Enactment.

Senate amendment

Requires that provider's claims not be paid before a period of 15 days has expired following receipt in FY 1990. Requires that 95% of clean claims be paid within 25 days of receipt, and within 20 days of receipt for participating physicians. Provides that any transfer of outlays, receipts, or revenues pursuant to this section is a necessary result of a significant policy change for purposes of sec-

tion 202 of the Balanced Budget and Emergency Deficit Control Reaffirmation Act of 1987.

Effective date

Enactment.

Conference agreement

The Conference agreement includes neither the House nor Senate provision.

2. Medicare as Secondary Payer

Section 10152 of House bill; section 5302 of Senate amendment.

Present law

(a) *Identification of Medicare secondary payer situations.*—Medicare is a secondary payer under specified circumstances when beneficiaries are covered by other third-party payers. Medicare is secondary payer to workers' compensation, automobile, medical, no-fault, and liability insurance. Medicare is also secondary payer to certain employer health plans covering aged and disabled beneficiaries and for end stage renal disease (ESRD) beneficiaries during the first 12 months of a beneficiary's entitlement to Medicare on the basis of ESRD.

HHS, through its contractors, currently identifies Medicare secondary payer cases through: beneficiary questionnaires; provider identification of third-party coverage when services are provided; and data transfers with other Federal and State agencies. According to HHS, approximately two-thirds of Medicare secondary payer cases are identified through these means.

Medicare contractors (insurance companies that process Medicare claims) are currently covered under the Privacy Act because they routinely handle beneficiary-specific information, including medical histories and social security numbers. Medicare contractors are currently prohibited from unauthorized disclosure of this information, subject to criminal penalties.

The Internal Revenue Code (IRC) prohibits disclosure of tax returns and return information of taxpayers, with exceptions for authorized disclosure to certain Governmental entities in certain specified instances. Any authorized recipient of tax return information must maintain a system of safeguards to protect against unauthorized disclosure of the information. No disclosure is allowed to third parties, such as employers and private insurers. Unauthorized disclosure is a felony punishable by a fine not exceeding \$5,000, or imprisonment of more than 5 years, or both. An action for civil damages also may be brought for unauthorized disclosure. Any authorized recipient of return information must maintain a system of safeguards to protect against unauthorized disclosure of the information.

(b) *Uniform enforcement and coordination of benefits.*—Medicare is secondary payer to employer group health plans, workers' compensation, automobile, medical, no-fault, and liability insurance. In cases involving liability insurance, providers are instructed to bill Medicare first for conditional payments, and Medicare subsequent-

ly recovers its costs from the liability insurer of the person who caused the injury.

Although payments made by primary employer group plans for working aged, disabled and ESRD beneficiaries are credited toward Medicare's deductible and coinsurance requirements, payments from workers' compensation and liability and related insurance are not counted toward Medicare's deductibles and coinsurance.

A variety of penalties exist to enforce compliance with the secondary payer provisions. Employers who do not comply with the working disabled provisions are subject to an excise tax equal to 25% of the group health plans' expenses. Failure to comply with the working aged provisions is a violation of the Age Discrimination in Employment Act of 1967, as amended. Employers who violate the secondary payer provisions for ESRD beneficiaries can lose their tax deduction for group health expenses.

(c) Special enrollment period for disabled employees.—Aged individuals are currently entitled to a special Medicare enrollment period if they are enrolled in a group health plan by reason of current employment. Under current law, disabled individuals are entitled to a special enrollment period only if they are covered under a large group health plan by reason of current employment.

(d) No matching based on private activities required in fiscal intermediary agreements and carrier contracts.—Under current law, the Secretary may terminate an agreement with a fiscal intermediary or carrier if he finds, after applying standards and criteria regarding claims processing and overall performance, that the entity has failed substantially to carry out the agreement or that the functions provided for in the agreement are disadvantageous or inconsistent with the efficient administration of the Medicare program.

(e) Treatment of employment as a member of a religious order.—The IRC permits religious orders whose members are required to take a vow of poverty to elect social security coverage, if such members perform tasks usually required of an active member of the order and are not retired because of old age or total disability. The IRC provides a method of computing the "wages" of members of such religious orders in order to apply the social security payroll tax, and considers such members to be "deemed employees."

Medicare is a secondary payer for aged individuals who have health insurance coverage from an employer, including religious orders. Religious orders are therefore required to provide the same health insurance coverage for their members who are age 65 and older as they do for members under age 64.

House bill

(a) Identification of Medicare secondary payer situations.—

(1) Disclosure of taxpayer identity information.—(A) *Return information from Internal Revenue Service.*—Amends the Internal Revenue Code (IRC) to require the Secretary of the Treasury to disclose to the Commissioner of Social Security available filing status and taxpayer identity information from the individual master files of IRS related to whether Medicare beneficiaries identified by the Commissioner are married (for

any specified year after 1986) and, if so, the name and Taxpayer Identification Number (TIN) of the beneficiary's spouse.

(B) *Return information from Social Security Administration.*—Upon written request, requires the Social Security Commissioner to disclose the following information to the HCFA Administrator: the name and TIN of each Medicare beneficiary identified as having received wages from a qualified employer in a previous year; for each married Medicare beneficiary whose spouse is identified as having received wages from a qualified employer in a previous year, the name and TIN of the beneficiary and the spouse; and, with respect to each such qualified employer, the name, address, and TIN of the employer and the number of individuals for whom the employer furnished W-2 forms for the previous year.

(C) *Disclosure by HCFA.*—Permits the HCFA Administrator to disclose the following information received from the Social Security Commissioner: (i) to the qualified employer, the name and TIN of Medicare beneficiaries and their spouses receiving wages from the employer, in order to determine the period during which such employees or the employees' spouses may be (or have been) covered under a group health plan of the employer and what benefits are (or were) covered under the plan (including the name, address, and identifying number of the plan); (ii) to any group health plan that provides coverage to such an employee or spouse, the name of such employee and the employee's spouse (if the spouse is a Medicare beneficiary), the name and address of the employer, and the TIN of the employee and/or spouse if Medicare benefits were paid during a period in which the plan was a primary plan; and (iii) to any agent of the HCFA Administrator, the name and TIN of Medicare beneficiaries and spouses receiving wages from a qualified employer and the name, address and TIN of their employers.

(D) *Special rules.*—Provides that information may be disclosed under this paragraph only to determine the extent to which any Medicare beneficiary is covered under any group health plan. Provides that any request made of the Secretary of Treasury or the Social Security Commissioner (as stated above) must be complied with as soon as possible, but no later than 120 days after the request is made.

(E) Provides for the following definitions:

Defines "Medicare beneficiary" as an individual entitled to benefits under Part A, or enrolled under Part B, of Medicare, but does not include an individual enrolled in Part A under the buy-in provisions of sec. 1818 (for the aged) or under the proposed buy-in provision for the disabled added by new sec. 10112(b) of this bill.

Defines "group health plan," to mean any group health plan or any large group health plan, as defined in IRC secs. 5000(b)(1) and 5000(b)(2).

Defines "qualified employer," for a calendar year, as an employer that has furnished W-2 statements to at least 20 individuals for wages paid in the year.

(F) *Termination.*—Provides that requirements for disclosing taxpayer identity information described in (A) and (B) above

shall not apply to (i) requests made after September 30, 1991, and (ii) any request made before such date for information relating to 1990 or thereafter for information required of the IRS (described in (A)) and that information required of the Social Security Commission (described in (B)).

(G) *Safeguards*.—Extends a number of existing IRC confidentiality safeguards to the taxpayer identity information for Medicare secondary payer purposes described in this section.

(H) *Penalty*.—Extends an existing IRC penalty on State and other employees for unauthorized disclosure of information (i.e., felony punishable by a fine not to exceed \$5,000, or imprisonment of not more than 5 years, or both, together with the costs of prosecution) to the unauthorized disclosure of taxpayer identity information for the Medicare secondary payer purposes described in this section.

(2) *Responsibilities of HCFA*.—(A) *In general*.—Amends the Social Security Act by requiring the Commissioner of Social Security, not less often than annually, to transmit to the Secretary of the Treasury a list of the names and TINs of Medicare beneficiaries and to request that the Secretary disclose to the Commissioner available filing status and taxpayer identity information relating to the spouses and spouse TINs of such beneficiaries.

Requires the HCFA Administrator, not less often than annually, to request the Social Security Commissioner to disclose to the Administrator information on the names and TINs of Medicare beneficiaries and their spouses receiving wages from qualified employers; the name, address, and TIN of such employers; and the number of individuals for whom the employer issued W-2 statements.

Requires the Administrator to disclose taxpayer identity information to intermediaries and carriers in order to determine instances where Medicare is the secondary payer.

Requires fiscal intermediaries and carries to contact qualified employers to determine during what period the employee or employee's spouse may be (or has been) covered under an employer group health plan and the nature of the coverage (including the name, address, and identifying number of the plan). Prior to Oct. 1, 1991, within 30 days of receipt of the inquiry, requires the employer to provide such information to the intermediary or carrier. Prior to Oct. 1, 1991, provides that an employer (other than a Federal or other governmental entity) who willfully or repeatedly fails to provide a timely and accurate response would be subject to a civil money penalty not to exceed \$1,000 for each individual with respect to which the inquiry is made; provides that the civil monetary penalty procedures of section 1128 of the Social Security Act would apply.

(B) *Deadline for first request*.—By Oct. 1, 1989, requires the Social Security Commissioner to first transmit to the Secretary of the Treasury the list of names and TINs of Medicare beneficiaries and to request from the Secretary disclosure of taxpayer identity information.

(b) *Uniform enforcement and coordination of benefits.*—Restructures and changes provisions in current law related to Medicare as secondary payer requirements.

(1) *Requirements of group health plans*—(A) *Working aged under group health plans.*—Provides that for items or services furnished to an individual age 65 or older covered as a current employee (or as a spouse) under a group health plan, the group health plan may not take into account the entitlement of an individual to Part A of Medicare. Requires that a group health plan must entitle any employee age 65 or older, and any employee's spouse age 65 or older, to the same benefits under the plan, under the same conditions, as any employee and the spouse of such employee under age 65.

Provides that these requirements do not apply to (i) group health plans sponsored by or contributed to by an employer that has fewer than 20 employees for each working day in each of 20 or more calendar weeks in the current or preceding calendar year; (ii) individuals enrolled in a multiemployer or multiple employer group health plan sponsored or contributed to by an employer with fewer than 20 employees for each working day in each of 20 or more calendar weeks in the current or preceding calendar year, if the plan elects to be excepted; and (iii) items or services furnished in a month to an individual if for the month the individual is, or would upon application be, entitled to benefits under sec. 226A (end stage renal disease).

Defines "group health plan" as provided in IRC sec. 5000(b)(1), as amended by this section.

(B) *Disabled active individuals in large group health plans.*—Prohibits, for items and services furnished on or after Jan. 1, 1987, and before Jan. 1, 1992, a large group health plan from taking into account that an active individual is entitled to benefits under Part A of Medicare.

Provides an exception to this requirement for items or services furnished in a month to an individual if, for the month, the individual is, or would upon application be, entitled to benefits under sec. 226A (end stage renal disease).

Defines "active individual" as an employee (as may be defined in regulations), the employer, a self-employed individual (such as the employer), an individual associated with the employer in a business relationship, or a member of the family of any such persons.

Defines "large group health plan" as provided in IRC sec. 5000(b)(2), as amended by this section.

(C) *Individuals with end stage renal disease.*—Prohibits a group health plan from taking into account that an individual is entitled to Medicare benefits solely by reason of sec. 226A (end stage renal disease) during the 12-month period which begins with the earlier of (i) the month in which a regular course of renal dialysis is initiated, or, (ii) in the case of an individual who receives a kidney transplant, the first month in which he would be eligible for Part A benefits (if he had filed an application for such benefits) under the end stage renal provisions of sec. 226A(b)(1)(B).

Prohibits a group health plan from differentiating in the benefits it provides (on the basis of the existence of end stage renal disease, the need for renal dialysis, or in any other manner) between individuals having end stage renal disease and other individuals covered by the plan. Provides that a plan may take into account that an individual is entitled to Medicare benefits on the basis of end stage renal disease after the end of the 12-month period described above.

(2) *Medicare secondary payer.*—Except for conditional payments described below, prohibits Medicare payment for items or services to the extent that payment has been made or can reasonably be expected to be made by a group health plan, or under a workers' compensation law or plan of the U.S. or a State, or under an automobile medical insurance policy or plan or no-fault insurance.

Defines "primary plan" to mean a group health plan or large group health plan, a workers' compensation law or plan, an automobile medical insurance policy or plan, or no-fault insurance which is required to pay for enrollee medical expenses regardless of Medicare coverage.

Provides that any conditional Medicare payment for items or services for which a primary plan or a liability insurance policy or plan (including a self-insured plan) is responsible is conditioned on reimbursement to the appropriate Medicare trust fund when notice or other information is received that the other policy or plan is primary.

Authorizes the U.S. to bring an action, in order to recover Medicare payments for an item or service, against any entity which is required or responsible to pay under a primary plan or a liability insurance policy or plan (and may collect double damages against that entity), or against any other entity (including any physician or provider) that has received payment from that entity. Authorizes the U.S. to join or intervene in any action related to the events that gave rise to the need for the item or service.

Provides that the U.S. will be subrogated (to the extent of the amount of Medicare's payment) to any right of an individual or any other entity to payment under a primary plan.

Provides that the Secretary may waive the provisions of this subparagraph in the case of an individual claim if the Secretary determines it is in the best interests of the Medicare program.

(3) *Enforcement.*—Establishes a private cause of action for damages (double the amount otherwise provided) where a primary plan fails to provide for primary payment or appropriate reimbursement.

Provides a reference to IRC sec. 5000, which imposes on any employer or employee organization that contributes to a non-conforming large group health plan (defined as a group health plan that does not pay primary benefits for the working aged, active disabled, or those with end stage renal disease) a tax equal to 25 percent of the employer's or employee organization's expenses incurred during the calendar year for each

large group health plan to which the employer or employee organization contributes.

(4) *Coordination of benefits.*—Provides that where payment by a primary plan is less than the charge for an item or service and is not payment in full, Medicare payment may be made (without regard to Medicare deductibles and coinsurance) for the remainder of the charge, except as provided below.

Provides that Medicare's payment cannot exceed the amount that Medicare would have paid as primary payer. In addition, Medicare's payment, when combined with the amount payable under the primary plan, cannot exceed the amount that would be paid by Medicare for the item or service on the basis of reasonable cost or under the Prospective Payment System, whichever is appropriate for that item or service. Where Medicare payment for an item or service is authorized on another basis, Medicare's payment for the remainder of the charge is the greater of either (A) the amount payable under the primary plan (without regard to its deductibles and coinsurance), or (B) the reasonable charge or other amount payable by Medicare (without regard to Medicare's deductibles and coinsurance).

(5) *Enforcement through excise tax.*—For purposes of applying the excise tax on nonconforming group health plans, amends the following definitions in IRC sec. 5000:

Defines "group health plan" as any plan of, or contributed to by, an employer (including a self-insured plan) to provide health care (directly or otherwise) to the employer's employees, former employees, or the families of such employees or former employees.

Defines "large group health plan" as a plan of, or contributed to by, an employer or employee organization (including a self-insured plan) to provide health care (directly or otherwise) to the employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families, that covers employees of at least one employee that normally employed at least 100 employees on a typical business day during the previous calendar year.

Defines "nonconforming group health plan" as a group health plan or large group health plan that at any time during a calendar year does not comply with the primary payer requirements for group health plans covering the working aged, the active disabled, and those with end stage renal disease, as required by sec. 1862(b)(1) of the Social Security Act.

(6) *Application of provider agreements in secondary payer situations.*—Amends Medicare's requirements for provider agreements (sec. 1866(a)(1)(A)) to prohibit providers from charging for items or services for which an individual would be entitled to Medicare payment if another policy or plan were not determined to be the primary payer.

(7) *Repeal of certain alternative enforcement provisions.*—Repeals sec. 162(i) of the Internal Revenue Code, which disallows as a deduction employer expenses for a group health plan if the plan discriminates against individuals having end stage renal disease or needing renal dialysis.

Amends the Age Discrimination in Employment Act of 1967 to strike sec. 4(g), which requires employers to offer coverage under a group health plan to employees and their spouses age 65 to 69 under the same conditions as to any employee or spouse under age 65.

(c) Special enrollment period for disabled employees.—Makes the special enrollment period for the disabled covered by an employer group health plan comparable to the special enrollment period for the aged covered under such a group health plan.

(d) No matching based on private activities required in Fiscal Intermediary Agreements and Carrier Contracts.—Prohibits the Secretary from requiring, as a condition of entering into or renewing agreements with fiscal intermediaries and carriers, that such intermediaries and carriers match data obtained through activities other than administering Medicare with data used to identify Medicare secondary payer situations.

(e) Treatment of employment as a member of a religious order.—Provides that an individual would not be considered to be employed or to be an employee for purposes of the Medicare secondary payer provisions if he or she is a member of a religious order whose members are required to take a vow of poverty and are considered “deemed employees” because of an election of social security coverage.

Effective date

(a)(1) effective Oct. 1, 1989; (a)(2) effective on enactment; (b) applies to items and services furnished after enactment; (c) applies to enrollments occurring after, and premiums for months after, the second calendar quarter beginning after enactment; (d) applies to agreements and contracts entered into or renewed on or after enactment; and (e) applies to items and services furnished on or after Oct. 1, 1989.

Senate amendment

(a) Identification of medicare secondary payer situations.—(a)(1) Similar provision. (a)(2) Similar provision, except provides for a deadline of Oct. 15, 1989 for the Social Security Commissioner to first transmit to the Secretary of the Treasury the list of names and TINs of Medicare beneficiaries and to request disclosure of taxpayer identity information.

(b) Uniform enforcement and coordination of benefits.—No provision.

(c) Special enrollment period for disabled employees.—No provision.

(d) No Matching based on private activities required in fiscal intermediary agreements and carrier contracts.—No provision.

(e) Treatment of employment as a member of a religious order.—No provision.

Effective date

(a)(1) effective Oct. 1, 1989; (a)(2) effective on enactment.

Conference agreement

(a) *Identification of Medicare secondary payer situations.*—The conference agreement includes the House provision, with amendments to change the effective date to date of enactment and to modify the deadline for the first request by the Commissioner of Social Security to no later than 14 days after the date of enactment.

(b) *Uniform enforcement and coordination of benefits.*—The conference agreement includes the House provision, with a change to include liability insurance (including a self-insured plan) in the definition of “primary plan” to which Medicare’s secondary payer provisions apply.

(c) *Special enrollment period for disabled employees.*—The conference agreement includes the House provision.

(d) *No matching based on private activities required in fiscal intermediary agreements and carrier contracts.*—The conference agreement includes the House provision.

(e) *Treatment of employment as a member of a religious order.*—The conference agreement includes the House provision.

3. End Stage Renal Disease

Sections 10153 and 4043 of House bill.

Present law

(a) *Maintenance of current composite rate.*—Under current law and regulation, dialysis facilities receive a prospectively determined rate for dialysis services. The rate is based on a single composite weighted formula which takes into account the mix of patients who receive dialysis at a facility or at home and the relative costs of providing such costs in such settings. A separate rate is established for hospital-based facilities and for independent facilities. In response to a regulatory effort to reduce dialysis payment rates, OBRA 86 mandated that rates in effect on May 13, 1986 be reduced by \$2 (which was less of a reduction than envisioned under regulatory proposals) and that such rates be maintained until October 1, 1988.

(b) *Limitation on amount of payment when patients deal directly with medicare suppliers.*—Under current law and regulations, beneficiaries may elect to obtain home dialysis equipment and supplies from a supplier other than an approved ESRD facility (a hospital-based or independent facility being reimbursed for dialysis services on the basis of a composite rate.) Reimbursement for such equipment and supplies is made on a reasonable charge basis. This type of reimbursement is referred to as Method II. Currently, average monthly payments to suppliers not participating in the ESRD facility program are nearly twice payments made under the composite rate system.

(c) *ESRD patient protection and quality assurance.*—Patient protection and quality assurance functions for ESRD patients and services are performed in part by end stage renal disease network organizations. Current law provides for seventeen network organizations to assure effective and efficient administration of ESRD benefits.

The responsibilities of the network organizations are as follows: (1) encouraging, consistent with sound medical practice, the use of treatment settings most compatible with successful rehabilitation of patients and the participation of patients, providers of services and renal disease facilities in vocational rehabilitation programs; (2) developing criteria and standards relating to the quality and appropriateness of patient care; (3) evaluating the procedure by which facilities and providers in the network assess the appropriateness of patients for proposed treatment modalities; (4) implementing a procedure for evaluating and resolving patient grievances; (5) conducting onsite reviews of facilities and providers (as determined by a medical review board or the Secretary) utilizing standards of care established by the network organization to assure proper medical care; (6) collecting, validating, and analyzing data necessary to prepare annual reports and to assure the maintenance of a national end stage renal disease registry; (7) identifying facilities and providers that are not cooperating toward meeting network goals and assisting them in developing appropriate plans for correction and reporting to the Secretary on facilities and providers that are not providing appropriate medical care; (8) submitting an annual report to the Secretary which includes a full statement of the network's goals, data on the network's performance in meeting its goals (including data on the comparative performance of facilities and providers with respect to the identification and placement of suitable candidates in self-care settings and transplantation and encouraging participation in vocational rehabilitation programs), identification of those facilities that have consistently failed to cooperate with network goals, and recommendations with respect to the need for additional or alternative services or facilities in the network in order to meet the network goals, including self-dialysis training, transplantation and organ procurement facilities; and (9) other duties prescribed by the Secretary.

Current regulations governing certification of ESRD facilities require establishment of standards regarding patients' rights, maintenance and distribution of medical records, maintenance of a long term care program for patients, reuse of hemodialysis filters and supplies, among other things. Regulations also specify the qualifications of directors and staff of renal dialysis facilities.

Under current federal law, the Secretary is authorized to make agreements with state agencies to conduct surveys and inspections of ESRD facilities to determine whether they comply with federal regulations governing them.

(d) Study of costs of treatment and establishment of composite rates.—No provision.

(e) Erythropoietin (EPO).—Medicare currently provides coverage for erythropoietin for renal dialysis patients if the drug is not self-administered. Payment is made in the form of an add-on to a facility's composite rate for dialysis. The amount of payment depends on the dosage administered. For doses less than 10,000 units, the payment is \$40. For administration of 10,000 or more units, the payment is \$70.

House bill

(a) *Maintenance of current composite rate.*—Section 10153.—Requires maintenance of the current composite rate until October 1, 1990.

Section 4043.—Requires maintenance of the current composite rate until October 1, 1989. Requires the Secretary to follow prescribed regulatory procedures (which include proposing rules and allowing for at least a 60-day comment period) before changing the composite rates in effect on September 30, 1989.

(b) *Limitation on amount of payment when patients deal directly with medicare suppliers.*—Section 10153.—Limits payments to suppliers who deal directly with ESRD patients (Method II) instead of through an approved ESRD facility to payments made under a single composite rate to an approved ESRD facility.

Requires written agreements with suppliers providing supplies and services directly to ESRD beneficiaries in order to be eligible for Medicare payments. The agreements must specify that the following conditions are met: (1) the patient certifies that the supplier is the sole provider of such supplies and equipment to the patient; (2) the supplier agrees to receive payment for the cost of such supplies and equipment only on an assignment-related basis; and (3) the supplier certifies that it has entered into a written agreement with an approved provider of services or renal dialysis facility under which the provider or facility agrees to furnish all self-care home dialysis support services and all other necessary dialysis services and supplies, including institutional dialysis services and supplies and emergency services.

Section 4043.—Similar provision limiting Method II payments to the composite rate. (No provision regarding stipulations required to suppliers reimbursed under Method II).

(c) *ESRD patient protection and quality assurance.*—Section 10153. Creates the End Stage Renal Disease Patient Protection and Quality Assurance Act of 1989 to expand protection of ESRD patients and provide further assurances of quality. Requires renal dialysis facilities to protect and promote the rights of patients regarding quality of care and provision of information about dialysis care. Facilities must inform patients about specified matters as soon as feasible, but not later than 30 days after the beginning of a dialysis program or course of treatment and upon reasonable request subsequent to the original provision of information.

(1) Information about the facility

Requires the facility to provide the following: (1) information about patients' rights provided by this section and patients' rights regarding grievance procedures; (2) information about services available in the facility and charges for them, including any charges for services not covered by Medicare; (3) information about facilities' responsibilities for continuing patients in dialysis programs and the specific circumstances that might result in termination from treatment; (4) the name of the physician with primary responsibility for coordinating a patient's care and the names and professional relationships of other physicians who will see the patient, if different from a patient's personal physician; (5) upon re-

quest, full information regarding the relationship of the facility to other organizations, corporations, or institutions, including disclosure of any physicians involved in patients' care who have a financial relationship with the facility; (6) upon request, and in accordance with applicable state law, access to a patient's own medical records maintained by a facility; and (7) information from the network organization about facilities in the region offering home or self-care dialysis and flexible arrangements and about facilities outside the region that will treat transient patients.

(2) Quality of care in treatment

Imposes additional requirements on facilities regarding quality of care in treatment. Requires facilities to inform patients about their medical condition through a physician and at regular intervals, unless provision of this information is medically contraindicated as documented in the patient's medical records. Facilities are also required to transmit such information to third parties upon the patient's request or because of medical necessity; Facilities must provide each patient, on at least an annual basis, an evaluation by a physician or an individual designated by a physician regarding the patient's suitability for a transplant or peritoneal or self-care dialysis. The facility is also required to maintain appropriate documentation of the evaluation of the patient's medical record.

Requires that each patient be provided, except in emergencies, and through a physician, with as much information as needed to give informed consent to any proposed treatment, including any experimental procedure or procedure involving reuse. The patient must be given sufficient information to understand the medically significant risks involved in the procedure or treatment, any alternative course of treatment, and the risks involved in the alternative course of treatment or in not treating the condition, and the name of the individual who will perform the procedure or treatment. Facilities may not refuse to treat a patient because the patient seeks other medical opinions regarding modes of treatment. Facilities are also authorized to permit a patient to refuse treatment, to the extent permitted by law and without jeopardizing the facility, if the facility has informed the patient, and the patient is aware of the medical consequences of refusing treatment.

Requires that each patient be provided with a written plan of care which assures a reasonable continuity of care and which includes designation of the agreed-upon treatment modality, advance notice of the time and location of appointments for dialysis treatments and the designation of the physician responsible for such care. This written plan of care is to be provided at regular intervals. Permits facilities to require patients to attest to a statement which affirms that they have been fully informed of their rights, that they understand various transplantation options, peritoneal dialysis, self-care dialysis and that they have consented to the written plan of care.

Requires facilities to treat each patient with consideration and respect and to promote patients' rights. Rights to be protected include the following: (1) right to privacy regarding accommodations, written and telephone communications, visits, meetings of patient and family groups, except that this does not include provision of a

private room; and (2) right to receive services with reasonable accommodation of individual needs and preference, except where the health or safety of the patient or other patients would be endangered.

Provides that facilities may only transfer or discharge a patient for medical reasons or for a patient's welfare, or that of other patients or staff, or for nonpayment of fees, except as prohibited by this section, and must provide a patient with advance notice of any transfer or discharge. A patient must consent to be transferred or discharged, except in specified cases. If the patient is a new patient or is medically unstable and the facility treating the patient is required, either by contract, state or local law, to routinely transfer the patient to another setting, a transfer is permitted. Facilities' written policies regarding transfers may not include as grounds for discharge or transfer the fact that the patient filed a grievance or legal complaint or that the patient refused to agree to reuse of artificial kidneys, if the such refusal is based on the written advice of a nephrologist that overriding medical reasons preclude reuse.

Requires facilities to ensure the confidential treatment of patients' personal and medical records, and may not release records to anyone outside the facility without the patient's consent, except if release is required in the case of a transfer to another institution, or if proper administration of the program requires it.

Requires that a registered professional nurse experienced in dialysis therapy be present during dialysis treatments at a facility to direct technicians providing dialysis services.

Prohibits facilities from interfering with the rights of patients to form patient councils or committees to discuss common concerns. In the case of facilities serving a significant number of people whose primary language is not English, facilities must provide information in a language and form understood by those patients.

Stipulates that rights provided to patients under this section also apply to guardians having legal responsibility for patients.

(3) Grievance procedure

Requires facilities to provide grievance procedures for resolution of patient concerns and conflicts and to permit patients to state grievances, report accidents and incidents and recommend changes in policies or services, directly or through any representative of choice, without restraint, interference or fear of reprisal.

(4) Survey and certification process

(A) State responsibilities

Directs states to certify, through surveys, the compliance of renal dialysis facilities and providers of services with the requirements imposed by this section. States are also responsible for conducting periodic educational programs for staff and patients of ESRD facilities in collaboration with network administrative organizations. The purpose of workshops is to present current regulations, procedures and policies. States are to transmit results of survey findings indicating that facilities are out of compliance with quality standards to network administrative organizations.

(B) Surveys

Defines standard surveys of ESRD facilities as including the following surveys for a sample of patients: (1) quality of care; (2) internal quality assurance program; (3) staffing, in-service training and consultant contracts; (4) written plans of care; (5) review of patient records; (6) compliance with patient rights; (7) interviews with patients; and (8) review of records for patients who died to determine quality of care.

Requires facilities to be surveyed without prior notice, and that a standard survey be conducted by December 31, 1992 and at least every 15 months thereafter. Standard surveys must also be conducted within 2 months of any change of ownership, administration, or management of a facility in order to determine whether the change has resulted in any decline in the quality of care.

Directs that facilities out of compliance with quality standards, as indicated by such factors as infection, hypotention, hospitalization, among others after consideration of case mix, be subject to an extended survey. At the discretion of the Secretary, other facilities may also be subject to an extended survey. The extended survey is to be conducted immediately after the standard survey, or not later than 2 weeks after the end of the standard survey.

Requires the survey team in an extended survey to review and identify the policies, procedures and quality assurance system which produced substandard care and is to determine whether the facility has complied with applicable standards and regulations. The extended survey is also to include a review of all of a facility's patient records and an expanded sample of patient interview to determine their satisfaction with care rendered. The survey team is to take into account whether the facility has a plan of correction and whether any evidence of immediate action exists. The Secretary may, without conducting an extended survey, impose a sanction based on the findings of a standard survey.

Requires that surveys be conducted based on a protocol developed, tested and validated by the Secretary no later than July 1, 1991 and by teams of surveyors who meet qualifications established by the Secretary. However, if the protocol are not developed by the date specified, States are still responsible for conducting surveys. The Secretary is to develop programs to reduce inconsistency among surveyors.

Requires that surveys be conducted by a multidisciplinary team of professionals, including a registered nurse. No member of a survey team may have been employed by the facility, either in a staff or consulting capacity, within the previous two years. In addition, no member of a survey team may have a personal or familial interest in the facility being surveyed.

Requires the Secretary to provide for a comprehensive training program for surveyors, and no one is permitted to serve as a surveyor unless they have completed a training and testing course approved by the Secretary.

If the Secretary has reason to question a facility's compliance with regulations, he may conduct a survey and make independent, binding determinations about the facility's compliance with regulations.

Directs that information obtained through surveys, including statements of deficiencies, are to be made available to the public. If a state, through the survey process, determines that a facility has provided substandard care, the state must notify the attending physician for each patient of the facility of the deficiency and of any plan to correct deficiencies. Information about grievances filed with ESRD network organizations and finding from the organization's investigations are to be provided to the facility administrator and patients filing such grievances. States may present awards of excellence to facilities providing exemplary care.

(5) Establishment of advisory board

Establishes a board to advise the Secretary, specifies the membership and legal functioning of the board, and defines its duties. The board is to have 11 members, to be composed of at least one of the following: an ESRD patient; a nephrologist; a renal administrator; a transplant surgeon; a nephrology nurse; a dialysis technician; a nephrology social worker; a renal nutritionist; a representative of a ESRD network administrative organization; and an expert in quality assessment or assurance.

Directs the board to advise the Secretary on development of the following: (1) quality standards; (2) protocols for surveys; (3) minimum qualifications for survey teams; (4) uniform national guidelines for surveyors, facilities and dialysis providers. The board is to make recommendations on these issues to the Secretary within a specified time period, and may make other recommendations on ways to improve administration of the ESRD program. The Secretary may implement appropriate recommendations, and is to notify the House Ways and Means and Energy and Commerce Committees and the Senate Finance of its implementation by January 1, 1992.

Requires the board to submit reports to the Secretary and these Congressional committees by the end of 1992 and 1994. The reports are to include the following: (1) recommendations to update quality standards; (2) an assessment of implementation of its recommendations; and (3) an assessment on which of its recommendations should be revised. Specifies the compensation of the board ability to hire staff, and the board's right to obtain information.

(6) Enforcement process

Extends the enforcement provisions applicable to skilled nursing facilities with deficiencies to ESRD facilities with deficiencies. Those provisions permit the Secretary to appoint temporary managers of facilities in cases where a survey reveals that conditions immediately jeopardize the health or safety of patients. In such cases, the Secretary is also authorized to terminate the facility's participation in Medicare. In cases where conditions do not immediately threaten the health or safety of patients, the Secretary is authorized to impose penalties consisting of the following: civil money penalties; denial of payment; or appointment of temporary management. Specifies that a temporary manager is to be an experienced facility administrator or licensed nephrologist in the state in which the facility is located. Deletes existing enforcement mechanisms.

(7) Duties and functions of ESRD network administrative organizations

Substantially revises the duties of ESRD network organizations by deleting all current law duties except the responsibility to encourage the most appropriate treatment settings for patients and the participation of patients in vocational rehabilitation programs. Substitutes instead the following duties: (1) assisting facilities found to be out-of-compliance; (2) developing network goals for placement of patients in self-care settings and transplantation; (3) conducting studies to assure that patients are assessed appropriately and to determine the number of patients returning to the work force; (4) implementing a procedure for evaluation and resolving patient grievances; (5) compiling information concerning facilities that offer home or self-care dialysis and provide flexible arrangements for patients returning to work; (6) conducting sufficient analytical work to prepare annual reports and assure maintenance of the ESRD registry; (7) advising facilities on the placement of patients; and (8) submitting an annual report to Congress.

Section 4043.—No provision.

(d) Study of the costs of treatment and establishment of composite rates.—*Section 10153.*—Requires the Director of the Office of Technology Assessment to conduct a study to determine the costs of various types of dialysis treatments and make recommendations regarding what the composite rate should be for Medicare dialysis services in FY 91 and the methodology that should be used to update the composite rate in subsequent years. The report is to be submitted to the House Committees on Ways and Means and Energy and Commerce and the Senate Finance Committee by June 1, 1990.

Section 4043.—No provision.

(e) Erythropoietin (EPO).—*Section 10153.*—Requires the Secretary to submit a report on the methodology and rationale used to establish a Medicare payment rate for the drug erythropoietin (EPO). The report is to include a summary of information provided by the manufacturer to the Secretary and used by him to establish the rate and a plan for ensuring the appropriateness of rates in the future. The report is to be submitted to the House Committees on Ways and Means and Energy and Commerce and the Senate Finance Committee by April 1, 1990.

The Comptroller General is directed to submit a report by June 1, 1990 to the same committees that review the information contained in the Secretary's report. By June 1, 1990, the Director of the Office of Technology Assessment is to submit a report to the same committees on alternative acquisition and reimbursement strategies for reducing expenditures for certain drugs for ESRD patients that does not adversely affect quality of care.

Section 4043.—No provision.

Effective date

Section 10153. Provision (a) takes effect as if included in the enactment of the Omnibus Budget Reconciliation Act of 1986. Provision (b)—Applies to dialysis services, supplies and equipment furnished on or after October 1, 1989. Provision (c)—applies to renal

dialysis facilities and providers, renal dialysis patients, ESRD network administrative organizations and States 6 months after the date of enactment, with two exceptions. The provision creating the Advisory Board is effective upon enactment. The provision repealing prior enforcement authority is effective January 1, 1993. Provisions (d) and (e)—Enactment.

Section 4043.—Applies with regard to dialysis services furnished on or after January 1, 1990.

Senate amendment

No provision.

Conference agreement

(a) *Maintenance of current composite rate.*—The Conference agreement includes the House provision to maintain the current composite rate until October 1, 1990, with the provision specified in Section 4043 requiring the Secretary to follow prescribed regulatory procedures before changing the composite rates in effect on September 30, 1990.

(b) *Limitation on amount of payment when patients deal directly with Medicare suppliers.*—The Conference agreement includes the House provision contained in Section 10153 with an amendment. The amendment would allow payment of 130 percent of the median composite payment for hospital-based facilities for dialysis (CCPD) who deal directly with Medicare suppliers (Method II). It includes the provision requiring written agreements with suppliers who provide services and supplies directly to Medicare beneficiaries. The amendment changes the effective date to February 1, 1990.

The Conference agreement also includes an amendment to reallocate funds remaining after each network administrative organization has received funds necessary to carry out its responsibilities. In reallocating funds, the Secretary is to ensure equitable treatment for all network organizations and take into account: (1) the geographic size of the network area; (2) the number of providers of end stage renal disease services in the network area; (3) the number of individuals who are entitled to end stage renal disease services in the network area; and (4) the proportion of the aggregate administrative funds collected in the network area.

The Conference agreement would also extend provisions that currently apply to PROs regarding protection against liability under Section 1157 and the prohibition against disclosure of information to ESRD network organizations which have entered into contracts with the Secretary.

(c) *ESRD patient protection and quality assurance.*—The conference does not include the House provision.

(d) *Study of costs of treatment and establishment of composite rates.*—No provision.

(e) *Erythropoietin (EPO).*—The Conference agreement includes the House provision with an amendment to strike the GAO report.

4. Medicare Hospital Patient Protection Amendments

Section 10155 of the House bill.

Present law

(a) *Scope of hospital responsibility for screening.*—If an individual (whether or not eligible for Medicare) comes to the emergency department of a hospital, and a request is made on the individual's behalf for examination or treatment of a medical condition, the hospital is required to provide for an appropriate medical screening examination, within the capability of the hospital emergency department, to determine whether or not an emergency medical condition exists or if the individual is in active labor. Within the capability of the staff and facilities available at the hospital, the hospital must provide medical services necessary to stabilize the individual or to provide for treatment of the labor. In the case of a patient who is not stabilized or who is in active labor, the hospital may transfer the patient if the patient requests that the transfer be effected, or if the benefit of transfer outweighs the risk of transfer, and if the transfer is an appropriate one.

(b) *Informed refusals of treatment or transfers.*—After the initial medical screening, a hospital is considered to have met the requirements for providing further examination and treatment, or appropriate and necessary transfer, if a patient (or a person acting on the patient's behalf) refuses the examination and treatment or transfer.

(c) *Authorization for transfer.*—If a patient at a hospital has an emergency medical condition which has not been stabilized, or is in active labor, the hospital may not transfer the patient unless (1) the patient (or a legally responsible person acting on the patient's behalf) requests that the transfer be effected, or (2) a physician (or other qualified medical personnel when a physician is not readily available in the emergency department) has signed a certification that, based upon the reasonable risks and benefits to the patient, and based upon the information available at the time, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual's medical condition from effecting the transfer. The transfer must also be an appropriate one, which requires that the receiving facility have available space and qualified personnel for the treatment of the patient and has agreed to accept transfer of the patient and to provide appropriate medical treatment.

(d) *Requiring maintenance of records of transfers.*—An appropriate transfer requires: that the transferring hospital provide the receiving facility with appropriate medical records (or copies thereof) of the examination and treatment effected at the transferring hospital; that the transfer is effected through qualified personnel and transportation equipment, including the use of necessary and medically appropriate life support measures during the transfer; and that the transfer meet other such requirements as the Secretary may find necessary in the interest of the health and safety of patients transferred.

(e) *Enforcement.*—Under the Medicare provider agreement, if a hospital knowingly and willfully, or negligently, fails to meet the requirements of this section, it is subject to termination of its provider agreement, or (at the option of the Secretary) suspension of

such agreement for such period of time as the Secretary determines to be appropriate, upon reasonable notice to the hospital and the public. A participating hospital that knowingly violates a requirement of this section, and the responsible physician, is subject to a civil money penalty of not more than \$50,000 for each violation. The responsible physician is subject to exclusion of up to 5 years from Medicare and Medicaid or a civil money penalty of not more than \$50,000 for each violation.

(f) Additional obligations.—

No provision.

*(g) Change in "patient" terminology.—*Current law generally uses the word "patient" to describe an individual who is present for emergency services.

(h) Clarification of "emergency medical condition" definition.—"Emergency medical condition" is defined in current law to mean a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in (1) placing the patient's health in serious jeopardy, (2) serious impairment to bodily functions, or (3) serious dysfunction of any bodily organ or part. Current law also defines "active labor" to mean labor at a time in which (1) delivery is imminent, (2) there is inadequate time to effect safe transfer to another hospital prior to delivery, or (3) a transfer may pose a threat to the health and safety of the patient or the unborn child. In addition, current law defines the term "to stabilize," and "stabilized." Defines that "to stabilize" means, with respect to emergency medical condition, to provide such medical treatment that may be necessary to assure, within reasonable medical probability, that no material deterioration to the condition is likely to result from the transfer of the individual from the facility. Defines that "stabilized" means, with respect to an emergency condition, that no material deterioration of the condition is likely within reasonable medical probability, to result from the transfer of the individual from the facility.

House bill

*(a) Scope of hospital responsibility for screening.—*Requires that the hospital provide for an appropriate medical screening examination within the capability of the hospital (not just within the hospital's emergency department).

*(b) Informed refusals of treatment or transfers.—*Provides that in the case of an individual (or a person acting on the individual's behalf) who refuses examination and treatment, or transfer, the hospital is required to explain to the individual (or the person acting on the individual's behalf) the risks and benefits of such examination and treatment, or transfer. Requires that the hospital take all reasonable steps to secure the written informed consent of the individual (or the person acting on the individual's behalf) to refuse examination and treatment, or transfer.

(c) Authorization for transfer.—

*(1) Informed consent for transfers.—*Provides that if an individual at a hospital has an emergency medical condition which has not been stabilized or is in active labor, the hospital may not transfer the individual unless, after being informed of the

hospital's obligations under this section and of the risk of transfer, the individual (or a legally responsible person acting on the individual's behalf) requests transfer to another facility.

(2) *Clarifying physician authorization for transfers.*—Provides that if a physician is not physically present in the emergency department at the time an individual is transferred, the hospital is prohibited from transferring the individual unless a qualified medical person (as defined by the Secretary in regulations) has signed a certification after a physician, in consultation with the person, has made the determination that the benefits outweigh the risks, and subsequently countersigns the certification.

(3) *Standard for authorizing transfer.*—Prohibits the hospital from transferring the individual unless a physician has signed a certification that, based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual, and, in the case of labor, to the unborn child.

(4) *Inclusion of summary of risks and benefits in certificate.*—Requires the certification to include a summary of the risks and benefits upon which the certification is based.

(5) *Provision of services pending transfer.*—Adds to the requirements for an appropriate transfer that the transferring hospital provide the medical treatment within its capacity which minimizes the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child.

(d) *Requiring maintenance of records of transfers.*—Requires the hospital that is transferring the individual to send to the receiving facility all available medical records (or copies thereof) related to the emergency condition for which the individual has presented, including records related to the individual's emergency medical condition, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests, and the informed written consent or certification (or copy thereof), and the name and address of any on-call physician who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment.

(e) *Enforcement.*—

(1) *Hospital liability.*—Provides that a participating hospital that violates a requirement of this section (whether or not it knowingly violates a requirement) is subject to a civil money penalty of not more than \$50,000 for each violation. Amends the subsection to provide that a hospital is liable for the acts and omissions of its agents and the physicians through whom it carries out its duties.

(2) *Physician liability.*—Amends the subsection relating to sanctions imposed on responsible physicians to provide for a civil money penalty of not more than \$50,000 for each violation, for any physician who is responsible for the examination, treatment, or transfer of an individual in a participating hospital (including a physician on-call for the care of such individual) and who violates a requirement of this section. This includes a physician who signs a certification that medical benefits reasonably expected from a transfer to another facility out-

weigh the risks associated with the transfer, if the physician knew or should have known that the benefits did not outweigh the risks, or misrepresents an individual's condition or other information, including a hospital's obligation under this section. Provides for exclusion of the physician from Medicare and State health care program participation if the violation is knowing and willful or negligent. Provides that if, after an initial examination, a physician (a) determines that the individual requires the services of an on-call physician (as defined under the law), (b) notifies that physician, and then the on-call physician fails or refuses to appear within a reasonable period of time, and (c) the physician orders the individual's transfer because the physician determines that without the services of the on-call physician the benefits of transfer outweigh the risks, then the physician authorizing the transfer is not subject to a civil money penalty. Provides that the penalty would still apply to the hospital or to the on-call physician who failed or refused to appear.

(f) *Additional obligations.*—Adds several new sections to current law.

(1) *Nondiscrimination.*—Prohibits a participating hospital that has specialized capabilities or facilities (such as burn units, shock-trauma units, neonatal intensive care units, or in rural areas, regional referral centers) from refusing to accept an appropriate transfer of an individual who requires such specialized capabilities or facilities if the hospital has the capacity to treat the individual.

(2) *No delay in examination or treatment.*—Prohibits a participating hospital from delaying provision of a required medical screening examination or treatment in order to inquire about the individual's method of payment or insurance status.

(3) *Whistleblower protections.*—Prohibits a participating hospital from penalizing or taking adverse action against a physician because the physician refuses to authorize the transfer of an individual with an emergency medical condition that has not been stabilized.

(g) *Change in "patient" terminology.*—Substitutes the word "individual" for "patient" at various points.

(h) *Clarification of "emergency medical condition" definition.*—Provides that "emergency medical condition" also applies to a condition that places in serious jeopardy the health of the woman or her unborn child. Provides that with respect to a pregnant woman who is having contractions, an "emergency medical condition" means that there is inadequate time to effect a safe transfer to another hospital before delivery, or that transfer may pose a threat to the health or safety of the woman or unborn child. Deletes the separate definition of the term "active labor." Changes the definition of "to stabilize" to include that no material deterioration to the condition is likely to occur during (as well as "likely to result from"), the transfer of the individual from the facility, or (with respect to a condition that could result in serious impairment to bodily functions) that may be necessary to deliver (including the placenta). Changes the definition of "to stabilize" and "stabilized" to include that no material deterioration of the condition is likely,

within reasonable medical probability, to occur during (as well as “result from”) the transfer of the individual from the facility, or (with respect to a condition that could result in serious impairment to bodily functions) that may be necessary to deliver (including the placenta).

Effective date

Effective on the first day of the first month beginning 180 days after enactment, without regard to whether implementing regulations have been promulgated by such date.

Senate amendment

No provision.

Conference agreement

The Conference agreement includes the House provision with amendments. The provision requires hospitals to provide screening within the capabilities of the hospital’s emergency department, including ancillary services routinely available to the emergency department. The provisions modifying the standard for hospital and physician liability for civil monetary penalties are deleted.

5. Health Maintenance Organizations (HMOs) and Competitive Medical Plans (CMPs)

Sections 10156 and 4041 of the House bill.

Present law

(a) *Physician incentive payments.*—Effective April 1, 1990, an HMO or CMP is subject to civil penalties if it makes a payment to a physician as an inducement to reduce or limit services to beneficiaries enrolled under a contract with Medicare or Medicaid. The penalty is up to \$2,000 for each enrollee with respect to whom such a payment is made.

(b) *Exclusion of prisoners and welfare beneficiaries from computation of 50/50 rule.*—In order to qualify for a Medicare risk contract, an HMO or CMP must have an enrolled population of which at least 50 percent are not Medicare or Medicaid beneficiaries.

(c) *Disclosure of AAPCC assumptions and methodologies.*—Medicare establishes per capita payment rates for different classes of HMO/CMP enrollees, grouped by age, sex, and other factors determined by the Secretary to be appropriate. (Factors currently in use include county, institutional status, basis of eligibility, and receipt of welfare benefits.) The rate for each class is equal to 95 percent of the average adjusted per capita cost (AAPCC) for that class, a projection of what Medicare would spend to provide covered services to a comparable group of beneficiaries not enrolled in the HMO/CMP. By September 7 of each year, the Secretary must announce the per capita rates to be used in the next calendar year.

(d) *Making authority for benefit stabilization fund permanent.*—Each HMO/CMP must develop an adjusted community rate (ACR), an estimate of what it would charge a private member comparable to a Medicare beneficiary for the scope of services covered under its Medicare contract. If an HMO/CMP’s ACR is lower than its aver-

age projected Medicare capitation payment, the HMO/CMP must use the difference to fund supplemental benefits or accept a reduced capitation rate. Alternatively, it may request that a portion of the difference be deposited in a benefit stabilization fund, to be drawn upon in a future year if the difference between the ACR and the Medicaid capitation rate is insufficient to continue financing the HMO/CMP's package of supplemental benefits. No fund may be established for a contract period beginning later than September 30, 1990; funds not used to pay for additional benefits within 4 years after their deposit revert to Medicare.

(e) *Temporary waiver for Watts Health Foundation.*—OBRA 87 waived the 50 percent private membership requirement for the Watts Health Foundation through January 1, 1990, and permitted a continued waiver after that date if the Secretary determined that the organization was making significant progress towards compliance with the requirement. If the Secretary does not so determine, he may, at any time after January 1, 1990, suspend further enrollment in the organization or suspend payment for new enrollees.

(f) *Limit on charges for emergency services and out-of-area coverage.*—HMO/CMP enrollees generally must receive services through providers employed by or contracting with the organization. In an emergency, or when an enrollee is outside the organization's service area and requires medical care, the HMO/CMP is financially responsible for covered services furnished by any qualified provider.

(g) *Increase to 100 percent of AAPCC.*—The Medicare per capita payment rate for each class of HMO/CMP enrollees is fixed at 95 percent of the average adjusted per capita cost (AAPCC) for that class of enrollees.

House bill

(a) Physician incentive payments

Section 10156—Repeals the current civil penalty provision with respect to Medicare (but not Medicaid) contracts. Requires the Secretary to identify, in consultation with representatives of HMOs and CMPs, physician incentive arrangements that may place physicians at excessive risk, lead to denial of necessary services, or compromise access or quality. Requires the Secretary to publish a description of high-risk compensation arrangements within 1 year after enactment. Provides that the Secretary may not enter into a risk-sharing contract with an organization unless the organization (a) certifies that it does not use the identified high-risk compensation arrangements or (b) provides detailed information on the compensation arrangements it does use, on any stop-loss or other mechanisms used to limit individual physicians' risk, and on its internal quality assurance systems. Permits the Secretary to impose civil money penalties or suspension of enrollments or payments if an organization uses a high-risk arrangement after certifying that it does not, substantially changes a compensation plan without notifying the Secretary, or uses an arrangement that creates an inducement for a physician to deny a specific medically necessary service to an identifiable patient.

Section 4041.—Repeals the civil money penalty provision with respect to both Medicare and Medicaid contracts.

(b) Exclusion of prisoners and welfare beneficiaries from computation of 50/50 rule

Section 10156.—Provides that, for the purposes of the 50 percent rule, prisoners or persons receiving medical coverage under a State or local general assistance program shall not be included in the count of non-Medicare, non-Medicaid enrollees.

Section 4041.—No provision.

(c) Disclosure of AAPCC assumptions and methodologies

Section 10156.—Requires the Secretary to publish an explanation of the methodology and assumptions (including benefit coverage assumptions) used in computing per capita rates at least 45 days before announcing the rates, beginning with the announcement for 1991. The explanation must be sufficiently detailed to permit an HMO/CMP to compute rates for each county or equivalent area in its service area.

Section 4041.—Similar provision, except that the detailed explanation of the methodology is to be published concurrently with the announcement of per capita rates. Requires that proposed changes in the methodology and assumptions from those used in the previous year be published 45 days before the rate announcement and that HMO/CMPs be given an opportunity to comment on the proposed changes.

(d) Making authority for benefit stabilization fund permanent

Section 10156.—Repeals the deadline for establishing a fund and the 4 year time limit on use of a fund.

Section 4041.—No provision.

(e) Temporary waiver for Watts Health Foundation

Section 10156.—No provision.

Section 4041.—Extends the waiver of the 50 percent requirement through January 1, 1994. Requires the Secretary, beginning January 1, 1990, to conduct an annual review of the organization's compliance with requirements for an internal quality assurance program. If the Secretary determines that the organization is not in compliance, he may, after notice to the organization and an opportunity to correct the deficiencies, suspend new enrollments or payments for beneficiaries enrolling after the date the Secretary notifies the organization of its non-compliance.

(f) Limit on charges for emergency services and out-of-area coverage

Section 10156.—No provision.

Section 4041.—Provides that, when a Medicare participating physician not under contract with an HMO/CMP furnishes emergency or out-of-area care to a Medicare HMO/CMP enrollee, the physician must accept as payment in full from the HMO/CMP the amount that would be allowed under Part B for the same service to a beneficiary not enrolled in an HMO/CMP. In the case of a non-participating physician, imposes the limits on actual charges that

would apply under Part B for the same service to a beneficiary not enrolled in an HMO/CMP.

(g) Increase to 100 percent of AAPCC

Section 10156.—No provision.

Section 4041.—Sets the Medicare payment rates for HMO/CMP enrollees at 100 percent of the AAPCC, beginning January 1990.

Effective date

Section 10156.—(a) applies to contracts entered into or renewed on or after April 1, 1991, except that the repeal of the current civil money penalty provision is effective on enactment. (b) applies to contracts entered into on or after the date of enactment. (c) and (d) are effective on enactment.

Section 4041.—(f) applies to services furnished on or after the date of enactment. (g) applies to payments for months beginning with January 1990. All other provisions are effective on enactment.

Senate amendment

No provision.

Conference agreement

(a) Physician incentive payments.—The conference agreement delays the effective date of the civil money penalty provision to April 1, 1991.

(b) Exclusion of prisoners and welfare beneficiaries from computation of 50/50 rule.—The conference agreement does not include the House provision.

(c) Disclosure of AAPCC assumptions and methodologies.—The conference agreement follows section 10156 of the House provision, except that the explanation is to be in the form of notice to the HMOs, rather than published.

In addition, the agreement modifies the current requirement that all HMOs/CMPs in an area must have a coordinated annual open enrollment period. A coordinated open enrollment period is required in an area only if the Medicare risk-sharing contract of one of the HMOs or CMPs in the area is not renewed or is terminated, or reduces its service area in such a way as to discontinue coverage for Medicare enrollees in part of the area.

In such a case, the remaining risk contractors in the area must have an open enrollment period for the Medicare enrollees losing coverage. The period must last 30 days and begin within 30 days after the Secretary notifies the organizations of the requirement. Enrollments will take effect 30 days after the end of the open enrollment period or, if the Secretary determines this is not feasible, on such other date as the Secretary specifies.

The Conferees expect that the Secretary will inform beneficiaries that a change in enrollment in a pre-paid plan may lead to loss of employer-related payments for additional benefits provided through the beneficiary's previous plan.

(d) Making authority for benefit stabilization fund permanent.—The conference agreement includes the House provision.

(e) Temporary waiver for watts health foundation.—The conference agreement includes the House provision.

(f) *Limit on charges for emergency services and out-of-area coverage.*—The conference agreement includes the House provision.

(g) *Increase to 100 percent of the AAPCC.*—The conference agreement does not include the House provision.

The conference agreement continues, for payments to Health Maintenance Organizations (HMOs) and Competitive Medical Plans (CMPs), the reductions in payment imposed under the sequester order of October 16, 1989, pursuant to the Balanced Budget and Emergency Deficit Control Act of 1985 (Gramm-Rudman-Hollings) through December 31, 1989. The agreement provides that no additional reduction in payments to HMOs and CMPs would occur as a result of a new sequester order under Title 11 of the Act. This would be accomplished by increasing payments to HMOs and CMPs for items or services provided on or after January 1, 1990 by a percentage amount (1.42 percent) equal to the amount of the reduction imposed pursuant to an order under Title 11.

6. Physician Ownership of, and Referral to, Health Care Entities

Section 10157 of the House bill.

Present law

Criminal penalties are provided for individuals or entities that knowingly and willfully offer, pay, solicit, or receive remuneration in order to induce business reimbursed under Medicare or State health care programs (including Medicaid, and any State program receiving funds under title V and title XX of the Social Security Act). The offense is classified as a felony and is punishable by fines of up to \$25,000 and imprisonment for up to five years. Remuneration includes kickbacks, bribes, rebates, and any other payment made directly or indirectly, overtly or covertly, in cash or in kind. Prohibited conduct includes not only remuneration intended to induce referrals of patients, but remuneration also intended to induce the purchasing, leasing, ordering, or arranging for any good, facility, service, or item paid by Medicare or State health care programs. With respect to home health services, a physician who has a significant ownership interest in, or a significant financial or contractual relationship with, a home health agency may not certify regarding a patient's need for home health services.

The Medicare and Medicaid Patient and Program Protection Act of 1987 (P.L. 100-93) provided authority to the Inspector General of the Department of Health and Human Services to exclude a person or entity from participation in Medicare and State health care programs if it is determined that the party is engaged in a prohibited remuneration scheme. The Act required the promulgation of regulations specifying those payment practices that will not be subject to criminal prosecution and that will not provide a basis for exclusion from the Medicare and State health care programs. These are sometimes referred to as "safe harbors." On January 23, 1989, the Secretary published a proposed rule to provide such "safe harbors." The rule has not yet been issued in final form.

The Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360) prohibited a home IV therapy provider from providing services to a Medicare beneficiary based on a referral from a physician who has

an ownership interest in, or receives compensation from, the provider. The prohibition also applies to ownership or compensation arrangements involving an immediate family member of the referring physician. The referring physician is defined as the physician who prescribes the home intravenous (IV) drug therapy or establishes a plan for such therapy. Several exceptions to this rule are provided: (1) ownership of publicly-traded stock purchased on terms available to the general public; (2) sole community rural home IV therapy providers; (3) compensation reasonably related to items or services actually provided by the physician which does not vary in proportion to the actual number of referrals made; (4) physicians whose only relationship with the provider is as an uncompensated officer or director of the provider; and (5) other exceptions established by the Secretary in regulation for ownership and compensation arrangements which the Secretary determines do not pose a substantial risk of program abuse. Payment is denied for services provided pursuant to a prohibited referral. The home IV therapy provider is also prohibited from billing for such services on an unassigned basis. A physician who knowingly and willfully accepts such a referral would be subject to civil money penalties of up to \$15,000 for each such referral and/or exclusion from the Medicare program.

The Medicare Catastrophic Coverage Act also required the Inspector General of HHS to study and report to Congress on the prevalence of self-referral arrangements and whether they lead to inappropriate utilization of services. In this report, the Inspector General identified limitations in the available data on physician ownership interests in entities providing services.

The Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272) requires the Secretary to establish a system that provides a unique identifier for each physician furnishing services to Medicare beneficiaries.

The Deficit Reduction Act of 1984 (P.L. 98-369) provided that Medicare would only pay the person actually providing clinical laboratory services. The purpose of this "direct billing" requirement was to prevent a physician from ordering a test and billing for it at a marked up price. An exception was provided for laboratory tests that were performed by a laboratory other than the one billing for the tests. This exception was designed to permit rural hospitals to utilize referral labs for tests they were unable to perform.

House bill

(a) *Prohibition of certain financial arrangements between referring physicians and providers of certain Medicare covered items and services.*—Amends the Social Security Act by adding new section 1877, "Limitation on Certain Physician Referrals." Except as specified below, prohibits a physician (or immediate family member of a physician) with an ownership or investment interest in an entity, or a compensation arrangement with an entity, from making a referral to that entity for the furnishing of an item or service for which Medicare would otherwise pay. Prohibits the entity from presenting or causing to be presented a Medicare claim or bill to any individual, third party payor, or other entity for an item or service furnished pursuant to a prohibited referral. Provides that

an ownership or investment interest may be through equity, debt, or other means.

(b) *General exceptions to both ownership and compensation arrangement prohibitions.*—Provides for the following exceptions to the prohibition on referrals:

(1) *Physicians' services.*—Physicians' services provided personally by (or under the personal supervision of) another physician in the same group practice as the referring physician;

(2) *Services of practitioners employed by a physician.*—Services of a physician's assistant, a certified nurse midwife, or a psychologist provided by a practitioner who is employed by a referring physician, by the same group practice as the referring physician, or by another physician in that same group practice;

(3) *In-office ancillary services.*—Medical and other health services (excluding durable medical equipment, ambulance services, and parental and enteral nutrition) if these are furnished personally by the referring physician, personally by a physician of the same group practice as the referring physician, or personally by individuals who are employed by such physician or group practice and who are personally supervised by the physician or by another physician in the group practice. Requires the services to be furnished in the same building in which the referring physician practices (or in the case of a referring physician in a group practice, in another building used by the group for the central provision of items and services other than physicians' services). Requires the services to be billed by the physician performing or supervising the services, by a group practice of which such a physician is a member, or by the entity that is wholly owned by such physician or such group practice. Requires the ownership or investment interest to meet such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse;

(4) *Prepaid plans.*—Services provided by a prepaid plan with a contract under sections 1876 or 1833 or a prepaid demonstration project;

(5) *Home intravenous drug therapy.*—Home intravenous drug therapy services subject to the restrictions of section 1834(d)(3), as added by the Medicare Catastrophic Coverage Act; and

(6) *Other permissible exceptions.*—In the case of any other financial relationship which the Secretary determines, and specifies in regulations, does not pose a risk of program or patient abuse.

(c) *General exception relating only to ownership or investment prohibition for ownership in publicly-traded securities.*— Provides an exception from the prohibition on referrals in a case of an ownership or investment if the ownership of investment securities (including shares or bonds, debentures, notes or other debt instruments) were purchased on terms generally available to the public and which are in a corporation that is: (1) listed for trading on the New York Stock Exchange, or the American Stock Exchange, or is a national market system traded under an automated interdealer quotation system operated by the National Association for Securi-

ties Dealers, and (2) had, at the end of the corporation's most recent fiscal year, total assets exceeding \$100,000,000.

(d) Additional exceptions related only to ownership or investment prohibition and subject to reporting and disclosure.—

(1) In general.—Provides that the following types of providers are not considered to have an ownership or investment interest if the reporting and disclosure requirements described below are met: (a) disproportionate share hospitals with a disproportionate patient percentage greater than 32 (as defined for purposes of the prospective payment system under section 1886) and hospitals in Puerto Rico; (b) a hospital in which a referring physician is authorized to perform services and the ownership interest is in the hospital itself (and not merely a subdivision thereof); and (3) entities which were substantially in operation before March 1, 1989. Defines "substantially in operation" to mean that the entity is actually providing items and services, binding contracts for building or equipment needed to provide such items and services have been signed, or the entity has received a certificate of need from the State with respect to the provision of such items and services. Provides that to qualify for the exception, the entity cannot have as an interested investor any individual who was not an investor in the entity as of March 1, 1989.

(2) Reporting requirements.—Provides that to qualify for the exception under this subsection, the entity must meet the following reporting and disclosure requirements: the entity must provide the Secretary with information concerning the entity's ownership arrangements, including the items and services provided by the entity, the names and the provider numbers of the referring physician investors, and any other information required by the Secretary to determine that the entity is in compliance with applicable law. Requires the information to be provided in the form, manner, and at such times as the Secretary specifies. Requires each physician who is an interested investor in an entity and who makes a referral of a Medicare patient to the entity, to disclose to the patient (in a form and manner specified by the Secretary) the physician's (or family member's) ownership interest in the entity. Requires that hospitals report information in accordance with the uniform hospital reporting system developed under section 4007(c) of the Omnibus Budget Reconciliation Act of 1987.

(e) Additional exceptions related only to ownership or investment prohibition and subject to reporting and disclosure and investment standards.—

(1) In general.—Provides that the following are not considered to be an ownership or investment interest if the reporting requirements described above are met and if each of the investment standards specified below is met: (a) any rural provider (meeting a specific definition); (b) an ambulatory surgical center for services performed personally by the referring physician; (c) a facility providing lithotripsy services for services performed personally by the referring physician at the facility; and (d) items and services (other than items and services furnished to inpatients) provided by a hospital joint venture in

which the hospital has a controlling interest, and an ownership interest, of at least 50% in the entity.

(2) *Description of investment standards.*—Specifies investment standards and provides that the Secretary's decision as to whether these investment standards have been met in any case is final, not subject to judicial review, and shall not control, or serve as a precedent in any other case. Provides that the standards are as follows: (a) investment in the entity must be open and offered on the same terms to disinterested investors as to interested investors; (b) the terms on which an investment interest is offered to an interested investor are not related to the previous or expected volume of referrals from that investor (or investor's family) to the entity; (c) the investment of each interested investor must bear the full risk of loss related to the investment; (d) the investment of each interested investor must be paid in full at the time of investment and may not be paid from funds or (or borrowed from) the entity or a related entity; (e) the amount of payment in return for the investment interest of an interested investor must be directly proportional to that person's capital investment; (f) the return on investment of an interested investor must be reasonable; (g) no requirement may be made that an investor (or investor's family) make or be in a position to make referrals of business to the entity as a condition of the investor's continued right to maintain an ownership interest; (h) investors (or investor's family) may not be encouraged to order services or otherwise refer business to the entity and the entity may not collect or maintain information on the volume of referrals of investors (and investor's family) other than information maintained in order to comply with applicable law; and (i) the entity must disclose, in a form and manner satisfactory to the Secretary, to individuals entitled to Medicare and receiving services at the entity, the relevant charges for such services and the professional qualifications of the entity to provide such services.

(3) *Discretionary application of standards.*—Authorizes the Secretary to withdraw the exception of an entity covered by this provision if the Secretary finds that (a) the entity has failed to disclose, in a form and manner specified by the Secretary, any circumstance which would cause the entity to be out of compliance with any of the investment standards; (b) the entity has failed to disclose periodically information relating to the entity's compliance with such standards; or (c) based on information in such a disclosure or otherwise, that the entity is no longer in compliance with each of the standards. The Secretary's withdrawal of an exception would be final and not subject to judicial review. In the case of a withdrawal due to a failure to disclose information which, if disclosed, would result in a finding of noncompliance, the Secretary is required to make the withdrawal effective as of the date of the failure.

(f) *Additional case-by-case exceptions related only to ownership or investment prohibition.*—

(1) *In general.*—Authorizes the Secretary to provide an exception to the referral prohibition with respect to ownership or investment interest if: (a) the entity demonstrates to the Secre-

tary's satisfaction that the items or services provided by the entity would otherwise be unavailable to the patients in the area to be served by the entity, the items and services provided by the entity would be more convenient for patients (defined by regulations based upon a reduction in travel time to the entity by at least 30 minutes for at least 75% of the patients, taking into account such factors as seasonal weather conditions), or the items and services provided by the entity would be provided at a substantially lower per unit charge and at a substantially lower cost overall to Medicare than any similar item or service in the area served by the entity; and (b) the entity applies to the Secretary for approval of the exception, the reporting and disclosure requirements are met, the Secretary determines that the investment standards are met, and there are no new interested investors in the entity on or after the date of approval of the application.—

(2) *Discretionary application of conditions.*—Provides that the Secretary's decision regarding the exception above shall be final and not subject to judicial review. Provides that such a decision in one case shall not control or serve as a precedent in any other case.

(3) *Fees.*—Authorizes the Secretary to require, as a condition of approval of an exception, payment of a reasonable fee to cover the necessary costs of processing and reviewing the exception.

(g) *Exceptions relating to other compensation arrangements.*—Provides that referrals are not prohibited for the following compensation arrangements:

(1) *Rental of office space.*—Provides that payments made for rental or lease of space are not prohibited compensation arrangements if: (a) there is a written agreement specifying the space covered by the agreement and dedicated for the use of the lessee; (b) provides for at least one year rental or lease; (c) provides for payment on a periodic basis of an amount consistent with fair market value; (d) provides for an amount of aggregate payments that does not vary based on the volume or value of any referrals of business between the parties; and (e) would be considered to be commercially reasonable even if no referrals were made between the parties. Requires that in the case of rental or lease of office space in which a physician who is an interested investor (or an interested investor who is an immediate family member of the physician) has an ownership interest, the office space is in the same building as the building in which the physician (or group practice of which the physician is a member) has a practice. Requires the arrangement to meet other requirements the Secretary may impose by regulation as needed to protect against program or patient abuse.

(2) *Employment and service arrangements with hospitals.*—Provides that an arrangement between a hospital and an interested investor for the employment of the interested investor or for the provision of administrative services and personnel is not a prohibited compensation arrangement if: (a) the arrangement is for identifiable services; (b) the amount of remuneration under the arrangement is consistent with the fair market

value of the services, and is not determined in a manner that takes into account the volume or value of any referrals by the physician; (c) the remuneration is provided pursuant to an agreement which would be considered to be commercially reasonable even if no referrals were made to the hospital; and (d) the arrangement meets other requirements the Secretary may impose by regulation as needed to protect against program or patient abuse.

(3) *Other administrative services.*—Provides that remuneration from an entity (other than a hospital) is not considered a prohibited compensation arrangement if the arrangement is: (a) for specific identifiable services as the medical director or as a member of a medical advisory board at the entity required under Medicare law; (b) for specific identifiable physicians' services to be furnished to an individual receiving hospice care if payment for such services may be made under Medicare as hospice care; or (c) for specific identifiable administrative services (other than direct patient care services) but only under exceptional circumstances specified by the Secretary in regulations. Requires, in addition, that the requirements specified above (relating to employment and service arrangements) are met with respect to the entity in the same manner as they apply to a hospital, and that the arrangement meets other requirements the Secretary may impose by regulation as needed to protect against program or patient abuse.

(4) *Physician recruitment.*—Provides that remuneration which is provided by a hospital to a physician to induce the physician to relocate to the area served by the hospital to become a member of the hospital's medical staff is not considered a prohibited compensation arrangement if: (a) the physician is not required to refer patients to the hospital; (b) the amount of the remuneration under the arrangement is not determined in a manner that takes into account the volume or value of any referrals by the referring physicians; and (c) the arrangement meets other requirements the Secretary may impose by regulation as needed to protect against program or patient abuse.

(5) *Isolated transactions.*—Provides that isolated financial transactions, such as a one-time sale of property, are not considered prohibited compensation arrangements if: (a) the requirements specified in subsection (2) with respect to employment and service arrangements are met with respect to the entity in the same manner as they apply to the hospital; and (b) the transaction meets other requirements the Secretary may impose by regulation as needed to protect against program or patient abuse.

(6) *Salaried physicians in a group practice.*—Provides that a compensation arrangement involving payment by a group practice of the salary of a physician member of the practice is not a prohibited compensation arrangement.

(h) *Sanctions.*—

(1) *Denial of payment.*—Prohibits Medicare payments for an item or service which is provided pursuant to a prohibited referral.

(2) *Requiring refunds for certain claims.*—Requires a person who collects money billed for a service provided pursuant to a prohibited referral to refund that money on a timely basis to the individual, and shall be liable to the individual for any amounts so collected.

(c) *Civil money penalty and exclusion for improper claims.*—Provides for a civil money penalty and exclusion from Medicare for any person who presents or causes to be presented a bill or claim for an item or service that such person knows or should know was provided pursuant to a prohibited referral, or who has not refunded that payment. Provides that the civil money penalty be not more than \$15,000 for each such item or service provided pursuant to a prohibited referral plus an amount equal to twice the amount billed for the item or service. Authorizes the Secretary to make a determination in the same proceeding to exclude the person from Medicare participation and to direct the appropriate State agency to exclude the person from participation in any State health care program. Provides for the Secretary to follow the same due process as specified in Section 1128A of the Social Security Act.

(4) *Civil money penalty and exclusion for circumvention schemes.*—Provides for civil money penalties in cases where a physician or other entity enters into an arrangement or scheme (such as a cross-referral arrangement) which the physician or entity knows or should know has as its principal purpose assuring referrals which, if they had been directly made, would be in violation of the prohibition on referrals. Limits the civil money penalty to not more than \$100,000 for each arrangement or scheme, plus an amount equal to twice the amount billed for the item or service. Authorizes the Secretary to make a determination in the same proceeding to exclude the person from Medicare participation and to direct the appropriate State agency to exclude the person from participation in any State health care program. Provides for the Secretary to follow the same due process procedures as specified in Section 1128A of the Social Security Act.

(5) *Failure to disclose information.*—Provides that any person who is required, but fails to meet a reporting requirement (specified above) or who knows or should know that a disclosure of any circumstance is required to be made to the Secretary and who fails to disclose, or causes the failure of such disclosure, is subject to a civil money penalty of not more than \$10,000 for each day for which disclosure is required to have been made.

(i) *Definitions.*—(1) Defines “compensation arrangement” to mean any arrangement involving any remuneration between a physician (or immediate family member) and an entity.

(2) Defines “remuneration” to include any remuneration, directly or indirectly, overtly or covertly, in cash or in kind.

(3) Provides that an individual is considered to be “employed” or “an employee” of any entity if the individual would be considered to be an employee of the entity under the usual common law applicable in determining the employer-employee relationship (as applied under a specific section of the Internal Revenue Code.)

(4) Defines "fair market value" as the value in arms length transactions, consistent with the general market value, and, with respect to rentals or leases, the value of rental property for general commercial purposes (not taking into account its intended use) and, in the case of a lease of space, not adjusted to reflect the additional value the prospective lessee or lessor would attribute to the proximity or convenience to the lessor where the lessor is a potential source of patient referrals to the lessee.

(5) Defines "group practice" to mean a group of two or more physicians legally organized as a partnership, professional corporation, foundation, not-for-profit corporation, faculty practice plan, or similar association: (a) in which each physician who is a member of the group provides substantially the full range of services which the physician routinely provides through the joint use of shared office space, facilities, equipment and personnel; (b) for which substantially all of the services of the physicians who are members of the group are provided through the group and are billed in the name of the group and amounts so received are treated as receipts of the group; (c) in which the overhead expenses of and the income from the practice are distributed in accordance with methods previously determined by members of the group; and (d) which meets such other standards as the Secretary may impose by regulation. Provides for an exception in the case of a faculty practice plan associated with a hospital with an approval medical residency training program in which physician members may provide a variety of different speciality services and provide professional services both within and outside the group.

(6) Defines "interested investor" to mean, with respect to an entity, an investor who is in a position to make or to influence referrals or business to the entity (or is an immediate family member of the investor). "Disinterested investor" means an investor other than an interested investor.

(7) Provides that except as specified under subsection (8) below, the following constitutes a "referral" by a "referring physician:" (a) the prescription of a Medicare covered out-patient drug by a physician, but only if the physician directs the patient to the specific pharmacy, home intravenous drug therapy provider, or other entity dispensing the drug; (b) in the case of an item or service which is required by law to be provided by or under the supervision of a physician, the request by a physician for the item or service, including the request by a physician for a consultation with another physician (and any test or procedure ordered by, or to be performed by, or under the supervision of, that other physician); and (c) the request or establishment of a plan of care by a physician for the provision of the item or services.

(8) Clarifies that the following does not constitute a "referral" by a "referring physician": (a) a request by a physician for physicians' services consisting solely of professional services to be furnished personally by that physician (or under the physician's personal supervision); (b) a request by a radiologist for diagnostic imaging services, by a physician specializing in the provision of radiation therapy services for such services, or by a pathologist for diagnostic clinical laboratory tests and pathological examination services, if such services are furnished by (or under the supervision of) such a

physician pursuant to a consultation requested by another physician; (c) a referral by a physician to a specialized cancer treatment pharmacy, if the pharmacy is engaged in the specific practice of providing chemotherapy treatment to diagnosed cancer patients and is not engaged in distributing general pharmaceuticals to the public; and (d) a referral by a physician to a freestanding or hospital based renal dialysis facility in conjunction with a renal dialysis procedure performed under the direction of the physician at the facility.

(j) Requiring requests for payment to include information on referring physician.—

(1) Requires that each request for payment, or bill submitted, for an item or service (other than physicians' services) furnished by an entity for which Medicare Part B payment may be made, and for which the entity knows or has reason to believe there has been a referral by a referring physician (as defined under new section 1877) include the name and provider number for the referring physician and indicate whether or not the referring physician is an interested investor.

(2) Provides that Medicare payment may be denied in the case of a request for payment for an item or service furnished by an entity under assignment and for which information on a referring physician is required but is not provided.

(3) Provides that in the case of a request for payment that is not submitted on an assignment-related basis and for which information on a referring physician is required but not provided, if the entity knowingly and willfully fails to provide such information promptly, the entity may be subject to a civil money penalty in an amount not to exceed \$2,000. Provides that, if after being notified by the Secretary, the entity knowingly, willfully, and in repeated cases fails to provide the information, the entity may be subject to exclusion from participation in programs under the Social Security Act for up to 5 years, in accordance with specified procedures of section 1128 of the Social Security Act providing for Medicare exclusions. Provides that specified sections of 1128A of the Act apply to civil money penalties authorized under this section in the same way as they apply in cases of false claims and other violations under section 1128A(a).

*(k) GAO study of hospital ownership and hospital joint ventures.—*Requires the GAO to conduct a study of the ownership of hospitals by referring physicians and of joint ventures between hospitals and referring physicians. Requires the study to investigate: (1) the types of ownership arrangements and types of services offered under such arrangements, (2) the returns generally earned by physician investors in such arrangements, (3) the effect of such arrangements of hospital admissions overall and in the communities served, other hospitals in the communities served, the utilization of services by Medicare beneficiaries, and Medicare expenditures, and (4) the effect of such arrangements on independent providers of services. Requires the GAO report to Congress on the results of the study by May 15, 1990.

Effective date

Applies with respect to referrals made on or after 180 days after enactment. Provides that the Secretary publish final regulations no later than 180 days after enactment. With respect to compensation arrangements that were entered into and became legally binding before March 1, 1989, effective for referrals two years after the date of enactment.

Senate amendment

No provision.

Conference agreement

(a) *Prohibition of certain financial arrangements between referring physicians and providers of certain Medicare covered items and services.*—The conference agreement includes the House provision, with an amendment. The prohibition of certain financial arrangements applies to clinical laboratory services with specific exceptions described below. An entity is prohibited from presenting, or causing to be presented, a Medicare claim or bill to an individual, third party payer, or other entity for clinical laboratory services furnished pursuant to a prohibited referral.

(b) *General exceptions to both ownership and compensation arrangement prohibitions.*—The conference agreement includes the House provision, with modifications. It deletes the provision relating to services of practitioners employed by physicians. The conference agreement also changes the provision relating to in-office ancillary services. The prohibition on referrals is effective January 1, 1992.

Under the agreement, the prohibition on referrals to an entity for the furnishing of clinical laboratory services does not apply in cases of services that are furnished: (1) personally by the referring physician, personally by a physician who is a member of the same group practice as the referring physician, or personally by individuals who are employed by such physician or group practice and who are personally supervised by the physician or by another physician in the group practice, and (2) in a building in which the referring physician (or another physician who is a member of the same group practice) furnishes physicians' services unrelated to the furnishing of clinical laboratory services, or in the case of a referring physician who is a member of a group practice, in another building which is used by the group practice for the centralized provision of the group's clinical laboratory services, and that are billed by the physician performing or supervising the services, by a group practice of which such physician is a member, or by an entity that is wholly owned by such physician or such group practice, if the ownership or investment interest in such services meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse. The conferees intend this exception to apply to a group practice which has set up its own central building to perform ancillary services for members of the group practice.*

The conference agreement also eliminates the exception for home intravenous drug therapy services.

(c) *General exception relating only to ownership or investment prohibition for ownership and publicly-traded securities.*—The conference agreement includes the House provision.

(d) *Additional exceptions related only to ownership or investment prohibition and subject to reporting and disclosure.*—The conference agreement includes the House provision, with modifications and an amendment. Under the general exceptions, excepts all clinical laboratory services provided by Puerto Rican hospitals. Excepts clinical laboratory services if the laboratory furnishing the services is in a rural area [as defined in section 1886(d)(2)(D)]. Applies the exceptions to hospital ownership in the case of clinical laboratory services provided by a hospital. Eliminates the provision excepting entities in operation before March 1, 1989.

The conference agreement also replaces the reporting and disclosure requirements required to qualify for the general exception under this subsection with a provision requiring each entity providing covered items and services for which Medicare payment may be made to provide the Secretary with information concerning the entity's ownership arrangements, including the covered items and services provided by the entity, and the names and all of the Medicare provider numbers of the physicians who are interested investors or who are immediate relatives of interested investors. The agreement requires this information to be provided in such form, manner, and at such times as the Secretary specifies. It requires that the information first be provided not later than one year after the date of enactment of this section.

(e) *Additional exceptions related only to ownership or investment prohibition and subject to reporting and disclosure and investment standards.*—No provision.

(f) *Additional case-by-case exceptions related only to ownership or investment prohibition.*—No provision.

(g) *Exceptions relating to other compensation arrangements.*—The conference agreement includes the House provision, with amendments. Under "employment and service arrangements with hospitals," the agreement deletes personnel. Under "other administrative services" it adds that referrals are not prohibited for a compensation arrangement if the arrangement is for specific physicians' services furnished to a nonprofit blood center.

(h) *Sanctions.*—The conference agreement includes the House provision, with modifications. It provides that no Medicare payment may be made for a clinical laboratory service which is provided pursuant to a prohibited referral. Replaces the provision relating to "failure to disclose information" with a provision that any person who is required, but fails, to meet a reporting requirement described above (see the reporting requirement described in (g) above) is subject to a civil money penalty of not more than \$10,000 for each day for which reporting is required to have been made.

(i) *Definitions.*—The conference agreement includes the House provision, with modifications: Under the definition for "referral; referring physician," it limits the definition to the case of a clinical laboratory services and deletes the section on prescriptions. Under "other items," the agreement limits the definition to a plan of care by a physician which includes the provision of the clinical laboratory service. Changes the "clarification respecting certain services in-

tegral to a consultation" to say that a request by a pathologist for clinical diagnostic laboratory tests and pathological examination services, if such services are furnished by (or under the supervision of) such pathologist pursuant to a consultation requested by another physician does not constitute a "referral" by a "referring physician." The conference agreement deletes a request by a physician specializing in the provision of radiation therapy services for such services, and deletes provisions relating to specialized cancer treatment pharmacies, and renal dialysis providers.

(j) Requiring requests for payment to include information on referring physicians.—The conference agreement includes the House provision with an amendment providing that each request for payment or bill submitted for an item of service striking (including physicians' services) must include the required information.

(k) GAO study of hospital ownership and hospital joint ventures.—The conference agreement includes the House provision, with modifications and an amendment. Requires GAO to conduct a study of ownership of hospitals and other Medicare providers by referring physicians. Requires the study to investigate: (1) the types of such ownership arrangements and types of services offered under such arrangements; (2) the returns generally earned by physician investors in such arrangements; (3) the effect of such arrangements on the utilization of items and services by Medicare beneficiaries, Medicare expenditures, and other entities providing items and services in the communities served; (4) the effect of such arrangements on independent providers of similar services; and (5) the effect on the provision of in-office clinical laboratory services of the limitation on payment for the referrals contained in this section. Requires GAO to report to Congress no later than February 1, 1991 on the results of the study.

The Conference Agreement also adds a requirement that the Secretary submit to Congress and the Comptroller General, not later than 90 days after the end of each calendar quarter, a report which provides a statistical profile (by State and type of item or service) comparing utilization of items and services by Medicare beneficiaries served by entities in which the referring physician has a direct or indirect financial interest, and by Medicare beneficiaries served by other entities.

The conferees wish to make clear that if the report by the GAO finds that referring physician ownership of hospitals and other providers of Medicare items or services or ownership interest in such entities by referring physicians leads to inappropriate use of services or inappropriately alters admission or utilization patterns in favor of entities or services in which physicians have an ownership interest, it would be the intent of the relevant Committees to consider legislation banning referrals at the earliest possible date. Investors in entities should take this possibility into account prior to investing in such arrangements.

(l) Requiring carriers to monitor and report overutilization.—No provision.

(m) Restriction of payment to referring laboratory.—No provision.

The Conference Agreement provides that the reporting requirement is effective October 1, 1990. All other requirements of the section are effective with respect to referrals made on or after Janu-

ary 1, 1991. The Conference Agreement requires the Secretary to publish final regulations to carry out section 1877 no later than October 1, 1990.

The conferees wish to clarify that any prohibition, exemption, or exception authorized under this provision in no way alters (or reflects on) the scope and application of the anti-kickback provisions in section 1128B of the Social Security Act. The conferees do not intend that this provision should be construed as affecting, or in any way interfering, with the efforts of the Inspector General to enforce current law, such as cases described in the recent Fraud Alert issued by the Inspector General. In particular, entities which would be eligible for a specific exemption would be subject to all of the provisions of current law.

7. Payments for Direct Graduate Medical Education

Section 4044 of the House bill.

Present law

Hospitals currently receive payments for the direct costs of graduate medical education, which include salaries and fringe benefits of residents, faculty and support staff, as well as approved overhead expenses. The payment amount is determined on the basis of hospital specific costs incurred per full time equivalent (FTE) resident. The FTE resident amount is determined by fully counting (1.0) the number of residents who are in their initial residency period (the minimum number of years of formal training necessary to satisfy the requirements for initial board eligibility plus one year), and by counting residents not in the initial residency period as one-half (0.5) FTE.

House bill

Requires the Secretary to count primary care residents as 1.25 FTE and primary care specialty residents as 1.10 FTE. Defines a primary care resident as a resident in family medicine, general internal medicine, or general pediatrics, and a primary care specialty resident as a resident in internal medicine or pediatrics.

Requires the Secretary to establish a national payment limit for each residency year beginning on or after July 1, 1990. When applied to all hospitals with graduate medical education programs, the national payment limit would result in an estimated aggregate reduction in payments in the residency year equal to the additional expenditures resulting from the new (greater than 1.0) weighting factors for primary care residents and primary care specialty residents.

Requires the Secretary to estimate for each hospital a "primary care coefficient" equal to the number of FTE residents (using the weighting factors) expected in the hospital in the residency year divided by the total number of FTE residents (determined without the weighting factors) expected in the hospital in a residency year. The limit on the approved FTE resident amount for a hospital is then determined as the product of the national payment limit and the primary care coefficient for the hospital for the residency year.

Effective date

Applies to residency years beginning on or after July 1, 1990.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House provision.

8. *Peer Review Organizations*

Section 10158 (a) and (b) and 4042 of House bill.

Present law

(a) *Peer review of non-physician services.*—Utilization and Quality Review Control Peer Review Organizations (PROs) are entities that contract with the Medicare program to review the services provided to Medicare patients to assure that services are medically necessary, provided in the appropriate setting, and meet professionally recognized standards of quality health care. Each PRO has a medical director, and a staff of nurse reviewers, data technicians and general support staff. In addition, each PRO has a board of directors, comprised of representatives from State medical societies, hospital associations and State medical specialty societies as well as a consumer representative. Finally, each PRO has a group of advisors who are consulted on cases on which there is a question regarding the nurse reviewer's decision. Only physicians can make initial determinations about services furnished or proposed to be furnished by another physician. However, nonphysician health care practitioners must be consulted before making a determination on a case involving the services provided by a nonphysician health care provider (e.g., services provided by a physical therapist).

(b) *Provider and practitioner right to reconsideration of PRO determination before notice to beneficiary.*—In reviewing the services provided to Medicare beneficiaries, a PRO may identify that care to be unreasonable or unnecessary, provided in an inappropriate setting or of substandard quality. After making such a finding, the PRO issues a preliminary notice to the physician or provider of such determination. The PRO is then required to give the physician or provider an opportunity for discussion and review of the proposed determination. If the PRO still disagrees with the physician or provider, it issues a formal notification to the physician or provider; such notification is also sent to fiscal intermediaries, carriers and the patient, and payment for service is denied. If reconsideration is requested, the PRO must complete the reconsideration within a specified time. Where the reconsideration is adverse to the beneficiary, and where the matter in controversy is \$200 or more, the beneficiary is entitled to a hearing by the Secretary. Where the amount in controversy is \$2,000 or more, the beneficiary is entitled to judicial review of the Secretary's final decision. Physicians and providers cannot appeal such a reconsideration.

(c) *Clarification of willing and able test for physician sanctions.*—If, after reasonable notice and opportunity for discussion with the practitioner or person concerned, a PRO determines that the prac-

tioner or person has failed in a substantial number of cases substantially to provide services that are necessary, appropriate and of a quality that meets professionally recognized standards of care, or if said practitioner or person grossly and flagrantly violates any of those obligations in one or more instances, the PRO must submit a report and recommendations to the Secretary. If the Secretary agrees with the PRO's determination, and determines that the practitioner or person has demonstrated an unwillingness or a lack of ability substantially to comply with the above obligations, the Secretary (in addition to any other sanction provided under the law) may exclude (permanently or temporarily) that person from eligibility to provide services under Medicare. Practitioners or persons who are dissatisfied with a determination made by the Secretary are entitled to reasonable notice and opportunity for a hearing, and judicial review of the Secretary's final decision.

(d) Increase in population threshold for preexclusion hearing.—Before the Secretary can exclude a provider or practitioner located in a rural health manpower shortage area or in a county with a population less than 70,000 from Medicare for failure to meet the specified obligations, the provider or practitioner is entitled to a hearing before an administrative law judge respecting whether the provider or practitioner should be able to continue providing services to Medicare beneficiaries, pending completion of the administrative review procedure as specified in the law. If the judge determines that the provider or practitioner does not pose a serious risk to Medicare beneficiaries if permitted to continue providing them services, the Secretary cannot effect the Medicare exclusion until the provider or practitioner has been provided with reasonable notice and an opportunity for an administrative hearing.

(e) Increase in civil monetary penalties.—The Secretary may require the payment of civil money penalties in lieu of program exclusion in cases where the practitioner or person has provided health care services which were medically improper or unnecessary. The amount is limited to the actual or estimated cost of the medically improper or unnecessary services.

House bill

(a) Peer review of non-physician services

Section 10158(a).—Amends the Social Security Act relating to functions of Peer Review Organizations to require that PROs establish procedures for the involvement of health care practitioners who are not doctors of medicine in the review of services provided by members of their profession.

Section 4042.—No provision.

Effective date

Applies to contracts entered into after enactment.

(b) Provider and practitioner right to reconsideration of PRO determination before notice to beneficiary

Section 10158(b).—Amends section 1154 of the Social Security Act relating to functions of Peer Review Organizations to require PROs, in the case of payment denials for poor quality of care, to

provide the physician or provider a reconsideration of the formal determination before notice is sent to patients, carriers and fiscal intermediaries. Provides that if a physician or provider is given a reconsideration, that reconsideration shall be in lieu of any subsequent reconsideration to which the provider or physician would otherwise be entitled. Preserves the right of a beneficiary to seek reconsideration of the PRO's determination. Provides that in the case of payment denials for poor quality of care that the notice to the patient state the following: "In the judgment of the peer review organization, the medical care received was not acceptable under the Medicare program. The reasons for the denial have been discussed with your physician and hospital."

Section 4042(a).—Similar provision.

Effective date

Section 10158(b).—Applies to PRO determinations with respect to which preliminary notifications are made, consistent with the notice timing requirements in law, more than 30 days after enactment.

Section 4042 (a).—Identical.

(c) Clarification of willing and able test for physician sanctions.—

Section 10158.—No provision.

Section 4042(b).—Amends section 1156(b)(1) relating to PRO sanctioning of physicians and providers to require, if appropriate, that in cases where the PRO has determined that such practitioner or person has failed to meet the specified obligations that the PRO give the practitioner or person an opportunity to pursue a recommended course of remedial education before the PRO submits a report and recommendations to the Secretary. Requires, in addition, that in determining whether a practitioner or person has demonstrated an unwillingness or a lack of ability substantially to comply with the specified obligations, the Secretary must take into account the practitioner's or person's refusal or willingness to pursue, or failure to comply with, an appropriate course of remedial education recommended by the PRO, or the practitioner's or person's failure or willingness to take any other corrective action on the practitioner's or person's own initiative before or during the administrative appeal.

Effective date

Applies with respect to recommendations for sanctions made by a PRO to the Secretary more than 90 days after enactment.

(d) Increase in population threshold for preexclusion hearing

Section 10158.—No provision.

Section 4042(c).—Replaces the current law requirement relating to counties with less than 70,000 to counties with less than 140,000.

Effective date

Applies to determinations made by the Secretary (under section 1156(b) of the law relating to sanctions and penalties) on or after enactment.

(e) Increase in civil monetary penalties.—

*Section 10158.—*No provision.

*Section 4042(d).—*Provides for a change in the civil money penalty from the actual or estimated cost of the medically improper or unnecessary services to \$2500.

Effective date

Enactment.

Senate amendment

No provision.

Conference agreement

*(a) Peer review of non-physician services.—*The Conference agreement includes the House provision.

*(b) Provider and practitioner right to reconsideration of PRO determination before notice to beneficiary.—*The Conference agreement includes the House provision.

*(c) Clarification of willing and able test for physician sanctions.—*The Conference agreement does not include the House provision.

*(d) Increase in population threshold for pre-exclusion hearing.—*The Conference agreement does not include the House provision.

*(e) Increase in civil monetary penalties.—*The Conference agreement does not include the House provision.

9. Miscellaneous and Technical Provisions Relating to Parts A and B

Sections 10158, 4045, 4061, 4062, and 4063 of House bill.

Present law

*(a) Determining eligibility of home health agencies for waiver of liability for denied claims.—*The Medicare program recognizes that circumstances may exist where providers of services or beneficiaries could not have reasonably known that certain services would not be covered by the program. The provider is presumed not to know that coverage for certain services would be denied, i.e., it qualifies for a "favorable presumption," when its denial rate is below a certain level. With this favorable presumption, it receives waiver of liability protection for denied claims below the threshold and it is paid for these claims. Home health agencies qualify for favorable presumption status if their denial rates are 2.5 percent or less. This denial rate is calculated based on a comparison of the number of home health visits submitted for Medicare payment in a calendar quarter compared to the number of visits for which payment is denied. An agency has 60 days in which to request reconsideration of a denial.

*(b) Extension of authority to contract with fiscal intermediaries and carriers on other than a cost basis.—*The Secretary contracts with fiscal intermediaries and carriers to pay claims for benefits under Medicare Part A and Part B respectively. The Deficit Reduction Act of 1984 (DEFRA) authorized the Secretary to enter into no more than two competitively bid contracts under Part A and two such contracts under Part B. The Secretary would only be allowed

to use this authority to replace poor performers, that is those falling into the lowest 20th percentile of all performers. DEFRA, as amended by OBRA-1986 authorized the Secretary to enter such contracts for fiscal years 1985-1989.

(c) Expansion of rural health medical education demonstration project.—OBRA 87 required the Secretary to conduct 3-year demonstration projects to assist resident physicians in developing field clinical experience in rural areas. Under the demonstration project, a sponsoring hospital provides a small rural hospital, for a period of one to three months of training, physicians who have completed one year of residency training.

The Secretary is required to select four small rural hospitals located in different counties to participate in the project, two of which are in rural counties of more than 2,700 square miles (one from either side of the Mississippi River) and two of which are located in rural counties with a severe shortage of physicians.

For the purposes of PPS payments, participating resident physicians are treated as if they are working in the sponsoring hospital and the sponsoring hospital receives an increased payment for direct graduate medical education costs incurred under the demonstration project.

(d) Cancer center treatment demonstration project and study.—Items and services which are not reasonable and necessary for the diagnosis or treatment of illness or injury, or to improve the functioning of a malformed body member, are excluded from Medicare coverage. This exclusion has been interpreted to apply to several medically unproven, experimental, or investigational procedures.

(e) Extension and clarification of prohibition on cost savings policies before beginning of fiscal year.—OBRA-1987 (as amended by P.L.100-360) prohibited the Secretary from issuing any regulation which affects the current services baseline for Medicare by more than \$50,000,000 prior to October 1989, unless required by law.

(f) Long-term care study.—No provision.

(g) Recognition of costs of certain hospital-based nursing schools.—The direct costs of approved medical education programs operated by a hospital are excluded from PPS and paid on a reasonable cost basis. HCFA has ruled that the costs of education programs operated at a hospital but controlled by another institution, such as a college or university, are not payable on a reasonable cost basis, but are included in PPS payment rates.

The Technical and Miscellaneous Revenue Act (TAMRA) of 1988 provided an exception to this rule for a hospital paid under a demonstration waiver that expired on September 30, 1985. If during its cost reporting period beginning in FY 1985 and for subsequent cost reporting periods, such a hospital has incurred substantial costs due to educational activities of a nursing college with which it share common directors, the activities shall be considered to be directly operated by the hospital for Medicare purposes, and shall be allowable as reasonable costs. Reimbursement is made on the same basis as if the costs were allowable direct costs of a hospital-operated approved educational program for cost reporting periods beginning in FY 1989, 1990, and 1991.

(h) Inner-city hospital triage demonstration project.—No provision.

(i) *GAO study of home health agency paperwork requirements.*—No provision.

(j) *GAO study of administrative costs of medicare program.*—No provision.

(k) *GAO review of long-term care insurance standards.*—No provision.

(l) *Distribution of information on recommended preventive health practices.*—The Secretary is required to distribute a notice containing information that explains the benefits available under Medicare, major categories of health care not provided by Medicare, limitations on payment (deductibles and coinsurance amounts), and a description of the limited benefits for long-term care services provided. The notice is mailed annually to individuals entitled to part A and part B benefits and when an individual applies for benefits under part A or enrolls in part B.

(m) *Administrative law judges for health-related cases.*—Administrative appeals involving Medicare and Medicaid are currently heard by administrative law judges from the Social Security Administration.

(n) *Amendments relating to the bipartisan commission on comprehensive health care.*—

(1) *Commission name.*—The U.S. Bipartisan Commission on Comprehensive Health Care was created by the Medicare Catastrophic Coverage Act to examine the shortcomings in current health care delivery and financing mechanisms that limit or prevent access of all individuals in the U.S. to comprehensive health care. It is required to make specific recommendations to the Congress on Federal programs, policies and financing needed to assure the availability of comprehensive long-term care services for the elderly and disabled, comprehensive health services for the elderly and disabled, and comprehensive health care services for all individuals in the U.S.

(2) *4 Vice chairman.*—Under current law, the Commission is composed of 15 members, 3 appointed by the President, 6 Senators appointed by the President Pro Tempore of the Senate and 6 House members appointed by the Speaker of the House. The Commission members are required to elect from its members a chairman and vice chairman.

(3) *Additional mailing privilege.*—Current law provides that the Commission may use the U.S. mail in the same manner and under the same conditions as Federal agencies.

(4) *Printing of reports.*—The Commission is required to submit two reports to Congress, one on comprehensive long term care services for the elderly and disabled, and one on comprehensive health care services for the elderly, disabled and all persons.

(5) *Report deadlines.*—Under the Technical and Miscellaneous Revenue Act of 1988 (P.L. 100-647), the original reporting dates for the Commission were extended from 6 months and one year after the date of enactment of the Medicare Catastrophic Coverage Act to 6 months and one year after the date of the first act providing appropriations for the Commission.

(o) *Office of rural health policy.*—The Office of Rural Health Policy, established by OBRA 87, is headed by a Director who pro-

vides advice to the Secretary on the effects of current policies and proposed statutory, regulatory, administrative, and budgetary changes established under Medicare and Medicaid on the financial viability of small rural hospitals, the ability of rural facilities to attract and retain physicians and other health professionals, and access to health care in rural areas. Currently, the office is within the Office of the Assistant Secretary for Health.

The Director is required to oversee compliance with certain statutory requirements pertaining to rural health issues, collect and distribute information on rural health care issues, research findings, and innovative approaches to the delivery of health care in rural areas, coordinate the activities with the Department relating to rural health care, and inform the Department of the activities of other Federal departments and agencies on rural health care issues.

House bill

(a) Determining eligibility of home health agencies for waiver of liability for denied claims.

Section 10158(c).—For purposes of calculating denial rates for favorable presumption status for home health agencies, requires that bills not be considered denied until the end of the 60-day period following the denial, or until the fiscal intermediary issues a decision on reconsideration of a denial. Also requires the Secretary to monitor the proportion of denied bills submitted by home health agencies for reconsideration and to notify Congress if the proportion of denials reversed upon reconsideration increases significantly.

Effective date

Enactment, with provisions for calculation of denial rates effective for quarters beginning on or after the date of enactment.

(b) Extension of authority to contract with fiscal intermediaries and carriers on other than a cost basis

Section 10158(d).—Extends the DEFRA authority for competitively bid contracting through FY1993 with two modifications. The period over which carrier performance is measured is defined as two years. In addition, the Secretary could enter into additional agreements and contracts without regard to cost reimbursement provisions if the contractor and the Secretary mutually agree to do so. The Secretary could not condition contract renewal, or otherwise require, that the contractor agree to waive cost reimbursement provisions.

Effective date

Applies beginning FY1990.

(c) Expansion of rural health medical education demonstration project.

Section 10158(e).—Expands the number of demonstration projects from four to ten. For new projects, waives the selection restrictions provided in the original Act (size of county and rural counties with severe physician shortage). The new demonstration projects are re-

quired to begin within six months of the date of enactment and to be conducted for three years.

Effective date

Enactment.

(d) Cancer center treatment demonstration project and study

Section 10158(f).—Requires the Secretary to establish a demonstration project no later than one year after enactment that will permit Medicare payment for 3 cost reporting periods to 2 cancer center hospitals for costs of experimental treatments under research protocols registered (if appropriate) with the National Cancer Institute and approved by the hospital's patient protection committee. If experimental drugs are used, they must be approved by the Food and Drug Administration for clinical trials.

Requires OTA to conduct a study of the appropriateness of Medicare reimbursement for experimental cancer treatment, including an analysis of the costs to the Medicare program of such reimbursement, whether such reimbursement should be limited to cancer center hospitals, and any controls the program should place on such reimbursement. Requires OTA to submit a report, no later than June 1, 1992, to the House Ways and Means Committee and the Senate Finance Committee.

Requires hospitals applying for the demonstration project to agree to share with the Office of Technology Assessment (OTA) data and other information relating to the experimental treatments for which the hospital is reimbursed under the demonstration project to assist OTA in conducting its study.

Effective date

Enactment.

(e) Extension and clarification of prohibition on cost savings policies before beginning of fiscal year.

Section 10158(g).—Extends and clarifies the DEFRA provision. The Secretary is prohibited from issuing any proposed or final regulation, instruction, or other policy which is estimated to reduce the current services baseline by more than \$50,000 with three exceptions. The Secretary may issue proposed changes prior to May 15 preceding the fiscal year and final rule-making or other changes after October 15 of the fiscal year. The Secretary may also, at any time, issue proposed or final regulation, instruction or other policy if specifically required by law. The provision applies for the period FY 1990-FY 1993, or if later, the last year for which there is a maximum deficit amount (i.e. Gramm-Rudman deficit target) specified under the Congressional Budget and Impoundment Control Act of 1974 (P.L. 93-344).

Effective date

Enactment.

(f) Long-term care study

Section 10158(h).—Requires the Secretary to request the Institute of Medicine (or another appropriate entity) to conduct a study of

existing public and private long-term care programs and demonstration projects, including continuing care retirement communities, Medicaid waiver programs, long-term care programs under the Older Americans Act, and other innovative public or private long-term care programs. Requires that the study—

(1) identify new benefits, programs, or payment methodologies that could be used to develop and provide long-term care benefits for Medicare beneficiaries;

(2) determine the extent to which coverage of new benefits under the Medicare program would meet the needs of these beneficiaries;

(3) examine the issues of financing, coverage, and administration related to long-term care;

(4) determine the availability and adequacy of personnel to provide long-term care services;

(5) outline the methods and analyze the effectiveness with which current long-term care programs recruit, train, and retain personnel; use functional status and disability measures to entitle beneficiaries to various levels of coverage; and take into account the presence of family support and other informal caregivers;

(6) determine how the adoption of new long-term care benefits under the Medicare program could be designed to complement programs and benefits already in place; and

(7) identify areas where information important to the successful implementation of a long-term care benefit program under Medicare is either incomplete or unavailable.

Requires the Secretary to submit a report on the study, together with any recommendations to Congress, by not later than 2 years after completion of arrangements with the Institute of Medicine or other appropriate entity for conduct of the study.

Effective date

Enactment.

(g) Recognition of costs of certain hospital-based nursing schools.

Section 10158(i).—Allows a hospital to be reimbursed on a reasonable cost basis for the costs of a hospital-based nursing school if, before June 15, 1989, and thereafter, the hospital incurred substantial costs in training students and operating the school, the nursing school and hospital share some common board members, and all instruction is provided at the hospital or in the immediate proximity of the hospital.

Allows a hospital paid under the TAMRA exception to be reimbursed for reasonable costs of training nursing students retroactively for hospital cost reporting periods beginning in FY 1986.

Effective date

Applies to cost reporting periods beginning on or after the date of enactment.

(h) Inner-city hospital triage demonstration project

Section 10158(j).—Requires the Secretary to establish a demonstration project in a public hospital located in a large urban area that has established a triage system. The Secretary is required to make payments for 3 years to reimburse the hospital for the reasonable costs of operating the system, including the costs of training hospital personnel to operate and participate in the system and costs of providing trauma and emergency services to patients who might otherwise be denied care. Limits payments under the project during a single year to \$500,000.

Effective date

Enactment.

(i) GAO study of home health agency paperwork requirements.

Section 10158(k).—Requires GAO to conduct a study analyzing the costs and effectiveness of current paperwork and other administrative requirements for home health agencies participating in Medicare, including an analysis of the feasibility of eliminating the separate reporting requirements for Medicare and Medicaid participation. Requires GAO to report to Congress on the study, together with any recommendations, by May 1, 1990.

Effective date

Enactment.

(j) GAO study of administrative costs of medicare program

Section 10158(l).—Requires GAO to conduct a study of the administrative burden of Medicare regulations and program requirements on providers of services, fiscal intermediaries, and carriers. The study is required to include an assessment of current administrative costs and trends since 1982, and a comparison with the administrative burdens of providing services to individuals who are not Medicare beneficiaries. Among the costs to be considered by the study are personnel costs, training costs, the costs of data and communications systems as affected by changes in requirements of the Medicare program, and costs of non-compliance with such requirements resulting from the failure of the Secretary to provide adequate notice of changes in program requirements. Requires the Comptroller General to submit a report to the House Committees on Ways and Means and Energy and Commerce and the Senate Committee on Finance by no later than March 31, 1990.

Effective date

Enactment.

(k) GAO review of long-term care insurance standards

Section 10158(m).—Requires GAO to conduct a review of the standards that may be used by States to regulate private long-term care insurance with respect to inflation protection, non-forfeiture of benefits, and other consumer protection provisions. Requires GAO to report to Congress on the result of its review by April 1, 1990.

Effective date

Enactment.

(l) Distribution of information on recommended preventive health practices

Section 4045.—Requires the Secretary to develop a summary of recommended preventive health care practices for elderly individuals entitled to Medicare benefits. If screening tests are recommended, the summary must indicate whether or not Medicare pays for the tests. Requires the Secretary to develop a 1-page form to be used as a personal and family medical history to assist physicians in furnishing appropriate health care. Requires the Secretary to consult with national physician, consumer, and other health-related groups in developing the summary and form, and base the form and summary on recommendations from an appropriate task force established by the Secretary. Requires the Secretary to provide for the distribution of the summary and form to each individual at the time of becoming eligible for Medicare and to other individuals at the time of general mailings.

Effective date

Enactment, with the development of the summary and form required by April 1, 1990, and the distribution of such materials by no later than October 1, 1990.

(m) Administrative law judges for health-related cases

Section 4061.—Adds a new section 1123 to the Social Security Act, "Administrative Law Judges for Health-Related Cases," which requires the Secretary to establish a group of administrative law judges devoted exclusively to hearing cases arising under Medicare, Medicaid or title XI of the Social Security Act (relating to peer review of utilization and quality of care), or arising out of a provision of part A of title XI relating to Medicare or Medicaid.

Effective date

Applies to hearings before administrative law judges conducted on or after January 1, 1990.

*(n) Amendments relating to the Bipartisan Commission on Comprehensive Health Care**(1) Commission name.—*

Section 4062.—Provides that the name of the Commission may also be known as the "Claude Pepper Commission" or the "Pepper Commission."

(2) 4 Vice chairmen.—

Section 4062.—Requires that the members of the Commission elect from its members 4 vice chairmen.

(3) Additional mailing privilege.—

Section 4062.—Amends current law to authorize the Commission to use the frank under the provisions for use of the frank by a commission of Congress as described in section 3215 of title 39 of the United States Code.

(4) Printing of reports.—

Section 4062.—Provides that for purposes of costs relating to printing and binding, including the costs of personnel detailed from the Government Printing Office, the Commission is to be deemed a committee Congress.

(5) Report deadlines.—

Section 4062.—Amends section 406 of the Medicare Catastrophic Coverage Act to require that the two reports be submitted concurrently not later than November 9, 1989.

Effective date

Enactment.

(o) Office of rural health policy

Section 4063.—Amends provisions for the Office of Rural Health Policy by changing the title of the Director to that of Deputy Under Secretary for Rural Health reporting directly to the Secretary. The Secretary is required to appoint the current Director of the Office as first Deputy Under Secretary no later than 30 days after enactment.

Requires the Deputy Under Secretary to collect and disseminate information on specific rural health issues, including mental health, infant mortality and pre-natal care, and occupational safety and preventive promotion, information on innovative approaches to health care delivery, and health education and promotion.

Effective date

Enactment.

Senate amendment

No provision.

Conference agreement

(a) Determining eligibility of home health agencies for waiver of liability for denied claims.—The conference agreement includes the House provision with an amendment. The amendment would require the Secretary to continue using the hospital-based wage index for home health agency cost limits until cost reporting periods beginning on or after July 1, 1991.

(b) Extension of authority to contract with fiscal intermediaries and carriers on other than a cost basis.—The conference agreement includes the House provision.

(c) Expansion of rural health medical health education demonstration project.—The conference agreement includes the House provision;

(d) Cancer center treatment demonstration project and study.—The conference agreement does not include the House provision.

(e) Extension and clarification of prohibition on cost savings policies before beginning of fiscal year.—The conference agreement includes the House provision with an amendment to extend the prohibition through October 15, 1990.

(f) Long-term care study.—The conference agreement does not include the House provision.

(g) Recognition of costs of certain hospital-based nursing schools.—The conference agreement includes the House provision

with amendments. The Secretary is prohibited from recouping, or otherwise reducing or adjusting, Medicare payments to hospitals before October 1, 1990, for alleged overpayments to hospitals as a result of a determination that costs reported for nursing and allied health education programs were allowable only as routine operating costs and therefore excluded from the medical education pass-through. The Secretary is required to issue regulations addressing payment of such costs by July 1, 1990, provided that the Secretary allows a comment period of not less than 60 days, consults with ProPAC, and any final rule is not effective before the later of October 1, 1990, or 30 days after publication in the Federal Register.

The regulations are to specify: (1) the relationship required between a hospital and an approved nursing or allied health education program for the program's costs to be attributed to the hospital; (2) the types of costs for such programs that are allowable; (3) the distinction between costs of educational activities eligible for pass-through and those treated as hospital operating costs; and (4) the treatment of other funding sources for the program.

The conferees expect the Secretary, in developing the regulations with respect to the relationship between a hospital and an educational program, to consider: (1) the degree of common ownership, broad membership, or control between the hospital, an educational institution, an academic medical center, a corporation or a related organization; (2) the degree to which instruction is provided in the immediate vicinity of the hospital; (3) the existence of a written agreement with an educational institution providing for joint activities in which the hospital incurs costs directly related to operation of the program; (4) reporting relationships or other affiliations between the educational institution, the hospital, and, if applicable, an academic medical center; and (5) the responsibility and control of the hospital for administering the education program.

The conferees further expect that rules relating to types of allowable costs shall consider such costs as clinical costs, operating costs, classroom costs, appropriately allocated overhead, and faculty supervision, and that the treatment of other funding sources shall take into account State or local funding and costs redistributed from non-provider sources.

The conferees wish to emphasize that, in providing reimbursement criteria for the costs of certain types of hospital-based nursing schools, it is not their intention to prejudice the Secretary's determination as to the appropriateness of cost reimbursement for other hospital-based nursing and allied health education programs. The conferees further note that a program will comply with the requirement that instruction be conducted in a building on the immediate grounds of the hospital only if this instruction occurs on the hospital campus, not on the campus of an institution with which the hospital is affiliated.

(h) Inner-city hospital triage demonstration project.—The conference agreement includes the House provision.

(i) GAO study of home health agency paperwork requirements.—The conference agreement does not include the House provision.

(j) GAO study of administrative costs of the Medicare Program.—The conference agreement includes the House provision.

(k) *GAO review of long-term care insurance standards.*—The conference agreement includes the House provision.

(l) *Distribution of information on recommended preventive health practices.*—The conference agreement does not include the House provision.

(m) *Administrative law judges for health-related cases.*—The conference agreement does not include the House provision.

(n) *Amendments relating to commissions.*—The conference agreement includes the House provisions with amendments.

The United States Bipartisan Commission on Comprehensive Health Care.—The conference agreement includes the House provision with an amendment to require that the reports be submitted by March 1, 1990.

The National Commission on Children.—The amendment extends the Commissioners' terms until March 31, 1991 and amends current law to provide that there be appropriated through fiscal year 1991 such sums as may be necessary. The Commission is authorized to accept donations of money, property or personal services.

(o) *Office of rural health policy.*—The conference agreement includes the House provision with an amendment to strike the provision requiring the appointment of a Deputy Under Secretary for Rural Health.

(p) *Extension of COBRA continuation coverage.*—The Conference agreement includes the House provision.

(q) *Other provision.*—The conference agreement also includes a provision to require the Secretary of HHS to enter into an agreement with the National Academy of Public Administration to study personnel administration at HCFA, to assess the adequacy of HCFA staffing and recommend any needed changes in HCFA staffing to the Secretary and the Congress.

10. Medical Care Quality Research and Improvement

Sections 10154 and 4101, 4111, 4121, 4131, 4132, 4133, 4134 and 4135 of the House bill.

Present law

(a) *In general.*—OBRA of 1986 (P.L. 99-509) amended section 1875 of the Social Security Act to provide for the establishment of a patient outcome assessment research program, administered by the National Center for Health Services Research and Health Care Technology (established under section 305 of the Public Health Service Act). The program is required to promote research with respect to patient outcomes of selected medical treatments and surgical procedures for the purpose of assessing their appropriateness, necessity, and effectiveness.

For the purposes of carrying out this research program, OBRA of 1986 authorized to be appropriated from the Medicare Trust Funds \$6 million for fiscal year 1987, and \$7.5 million for each of fiscal year 1988 and fiscal year 1989. These authorization amounts were increased by the Technical and Miscellaneous Revenue Act of 1988 (P.L. 100-647) to \$10 million for fiscal year 1989, \$20 million for

fiscal year 1990, and \$30 million for fiscal year 1991, and the authorization was extended through fiscal year 1991.

OBRA of 1986 also requires the National Center for Health Services Research (NCHSR) to establish application procedures for grants and cooperative agreements, and to establish peer review panels to review all such applications and research findings. NCHSR is also required to consult with the Council on Health Care Technology in establishing the scope of and priorities for the research program and to report periodically to the Council on the status of the program. The Secretary is required to make available to this research program data derived from Medicare research programs and other programs administered by the Secretary.

In addition, NCHSR is required by OBRA of 1986 to report to the Senate Committees on Finance and Appropriations and the House Committees on Ways and Means, Energy and Commerce, and Appropriations not later than 18 months after enactment, and annually thereafter, on the findings of the research program. In cooperation with appropriate medical groups, the Center is required to disseminate its findings as widely as possible, including to the peer review organizations (PROs).

(b) Establishment of research and education program.—Under current law, the purpose of the existing patient outcome assessment research program is to promote research with respect to patient outcomes of selected medical treatments and surgical procedures to assess their appropriateness, necessity, and effectiveness. This research program includes: (1) reorganization of Medicare claims data in a manner that facilitates research on patient outcomes; (2) assessments of the appropriateness of admissions and discharges; (3) assessments of the extent of professional uncertainty regarding efficacy; (4) development of improved methods for measuring patient outcomes; (5) evaluations of patient outcomes; and (6) evaluation of the effects on physicians' practice patterns of the dissemination to physicians and PROs of the findings of outcomes research.

(c) Priority with respect to certain health conditions.—In selecting treatments and procedures to be studied under the existing patient outcome assessment research program, the Secretary is required to give priority to those medical and surgical treatment procedures for which data indicate a highly (or potentially highly) variable pattern of utilization among Medicare beneficiaries in different geographic areas, and which are significant (or potentially significant) to Medicare in respect to utilization, length of hospitalization associated with the treatment or procedure, costs to the research program, and risk involved to the beneficiary.

(d) Standards for data bases.—No provision.

(e) Dissemination of findings and education of providers.—Under the patient outcome assessment research program established by OBRA of 1986, the National Center for Health Services Research, in cooperation with appropriate medical groups, is required to disseminate the findings of the research program as widely as possible, including to the peer review organizations (PROs).

(f) Development of practice guidelines.—No provision.

(g) Medicare demonstration project.—No provision.

(h) *Reports to Congress.*—Under OBRA of 1986, the National Center for Health Services Research is required to report to the Senate Committees on Finance and Appropriations and the House Committees on Ways and Means, Energy and Commerce, and Appropriations not later than 18 months after enactment, and annually thereafter, on the findings of the patient outcome assessment research program.

(i) *Advisory council.*—No provision.

(j) *Coordinating group.*—No provision.

(k) *Authorization of appropriations.*—For the purposes of carrying out the patient outcomes assessment research program, OBRA of 1986 (P.L. 99-509) authorized to be appropriated from the Medicare Trust Funds \$6 million for fiscal year 1987, and \$7.5 million for each of fiscal year 1988 and fiscal year 1989. These authorization amounts were increased by the Technical and Miscellaneous Revenue Act of 1988 (P.L. 100-647) to \$10 million for fiscal year 1989, \$20 million for fiscal year 1990, and \$30 million for fiscal year 1991, and the authorization was extended through fiscal year 1991.

(l) *Definitions.*—No provision.

(m) *Establishment of the Agency for Health Care Research and Policy.*—Initial authority for a government health services research program was enacted in 1967 under the Public Health Service (PHS) Act, followed by various pieces of legislation that modified, extended and improved this program. In 1974, legislation established the National Centers for Health Services Research, which was later expanded to include Health Care Technology Assessment.

Under the PHS Act, the Secretary, acting through the National Center for Health Services Research and Health Care Technology Assessment (NCHSR) and the National Center for Health Statistics (NCHS), is required to conduct and support research, demonstrations, evaluations, and statistical and epidemiological activities for the purpose of improving the effectiveness, efficiency, and quality of health services in the United States.

(n) *General authorities and duties of the agency.*—NCHSR is responsible for planning, developing, and administering a program of health services research, demonstrations, evaluations, research training, and related grant and contract support activities relating to the financing, organization, quality, and utilization of health care services. The Center disseminates research findings and gives technical assistance to other Federal programs and health service providers. In the area of technology assessment, the Center supports studies on the safety, efficacy, and cost-effectiveness of specific technologies, development of new methods for evaluating medical technologies, and diffusion of medical technology. Current authority for NCHSR expires at the end of fiscal year 1990.

The PHS Act requires that the Secretary, acting through NCHSR, undertake and support research, evaluation, and demonstration projects (that may include and are to be coordinated with experiments and demonstration activities authorized by the Social Security Act respecting the delivery of health care services in rural areas (including frontier areas), which may include projects with respect to (1) the future of the rural hospital; (2) long-term health care for the rural elderly; (3) hospital care for the rural poor and uninsured; (4) alternative health care delivery systems and man-

aged health care in rural areas. The law requires the Secretary to afford appropriate consideration to requests of State, regional and local health planning and health agencies; public and private entities and individuals engaged in the delivery of health care, and other persons concerned with health services to have NCHSR or other units of HHS undertake research, evaluations, and demonstrations respecting specific aspects of specified issues, including access, quality, supply, distribution and costs.

(o) *Dissemination by the administrator of the agency for health care research and policy.*—The PHS Act requires the Secretary, acting through NCHSR, to give appropriate emphasis to research, demonstrations, evaluations and statistical and epidemiological activities respecting the collection, analyses, and dissemination of health related statistics, alternative methods for disseminating knowledge concerning health and health related activities. In addition, the PHS Act requires the Secretary to publish, make available, and disseminate the results of health services research, demonstrations, and evaluations. It also requires the Secretary to make available to the public data developed in such research, demonstrations, and evaluations, and to provide indexing, abstracting, translating and other services leading to a more effective and timely dissemination of information.

Current law prohibits the Secretary from restricting the publication and dissemination of data from, and results of, projects undertaken by specified centers. It also requires the Secretary to act as needed to assure that statistics are of high quality, timely, comprehensive, etc. and are disseminated as widely as practicable.

The PHS Act currently prohibits the use of information for any purpose other than the purpose for which it was supplied, if an establishment or person supplying that information or described in it is identifiable, unless that establishment or person has consented to its use and other specified conditions are met.

(p) *Health care technology and technology assessment.*—Under the PHS Act, the Secretary, acting through NCHSR, is required to undertake and support (by grant or contract) research regarding technology diffusion, methods to assess health care technology, and specific health care technologies. The Act also establishes a National Advisory Council on Health Care Technology Assessment to advise the Secretary and the Director of NCHSR with respect to the performance of health care technology assessment functions, and specifies the composition, funding, and organization of the Council. The purposes of the Council include promoting the development and application of appropriate health care technology assessments, and the review of existing health care technologies in order to identify obsolete or inappropriately used health care technologies.

The PHS Act requires the Council to make recommendations to the Director of NCHSR with respect to the development of criteria and methods to be used by the Center in making health care technology coverage recommendations. It further requires that NCHSR advise the Secretary respecting health care technology issues and make recommendations with respect to whether specific technologies should be reimbursable under Federally financed health programs. In making these recommendations, the law requires NCHSR to consider the safety, efficacy, and effectiveness, and as

appropriate, the cost-effectiveness and appropriate uses of the technology. NCHSR is required to cooperate and consult with NIH, FDA, and other interested Federal departments or agencies.

The Act requires, in addition, that the Secretary make grants for the planning, development, establishment, and operation of the Council, and specifies the conditions by which an entity can obtain a grant.

(q) Establishment of the forum for quality and effectiveness in health care.—No provision.

(r) Forum/panels of experts and consumers.—No provision.

(s) Additional requirements for the forum for quality and effectiveness.—No provision.

(t) Additional authorities and duties of the agency for health care research and policy.—No provision.

(u) Peer review with respect to grants and contracts.—Under the PHS Act, no grant or contract may be made under specified sections of the law (relating to NCHSR and NCHS) unless an application for the grant has been submitted to the Secretary in such form and manner, and containing such information, as the Secretary may prescribe (through regulation) and unless a peer review group (as established by the Secretary through the Directors of NCHSR and NCHS) has recommended the application for approval. In addition, each application submitted for a grant or contract in an amount exceeding \$50,000 of direct costs and for a health services research, evaluation, or demonstration project, has to be submitted to a peer review group for an evaluation of the technical and scientific merits of the proposals made in each application. The law requires the peer review groups to report their findings and recommendations to the Secretary, acting through the Director involved. The Secretary is not allowed to approve an application unless a peer review group has recommended the application for approval.

(v) Provisions with respect to development, collection, and dissemination of data.—No provision.

(w) Additional provisions with respect to grants and contracts.—Under the PHS Act, no grant or contract may be made under specified sections of the law (respecting NCHSR and NCHS), unless an application for the grant has been submitted to the Secretary in such form and manner, and containing such information, as the Secretary may prescribe (through regulation) and unless a peer review group (as established by the Secretary through the Directors of NCHSR and NCHS) has recommended the application for approval. In addition, each application submitted for a grant or contract in an amount exceeding \$50,000 of direct costs and for a health services research, evaluation, or demonstration project, has to be submitted to a peer review group for an evaluation of the technical and scientific merits of the proposals made in each application. The law requires the peer review groups to report their findings and recommendations to the Secretary, acting through the Director involved. The Secretary is not allowed to approve an application unless a peer review group has recommended the application for approval.

The Act also provides that amounts otherwise payable to a person under a grant or contract are to be reduced by: (a) amounts equal to the fair market value of any equipment or supplies fur-

nished by the Secretary to carry out the project for which the grant was made; and (b) amounts equal to the pay, allowances, traveling expenses, etc. attributable to the performance of services by an officer or employee of the Federal Government in connection with the project, if that officer or employee was assigned or detailed by the Secretary, but only if the person requested the Secretary to furnish the equipment or supplies or the services of the Government officer or employee.

(x) *Certain administrative authorities.*—The PHS Act provides for the establishment of NCHSR and NCHS, including the appointment of officers and staff, the acquisition of facilities and equipment, and the appointment of advisory councils and committees.

(y) *Funding of the Agency for Health Care Research and Policy.*—The PHS Act currently authorizes appropriations for health service research, evaluation, and demonstrations under sections 304 or 305 (relating to general authorities and specific authority for NCHSR), \$30 million for FY 1988 and such sums as may be necessary for FY 1989 and FY 1990.

At least 20 percent of the amount appropriated for any fiscal year or \$6 million, whichever is less, is to be available only for health services research, evaluation, and demonstration activities directly undertaken through NCHSR, and at least 10 percent of such amount or \$1.5 million, whichever is less, is to be available only for the user liaison program and the technical assistance programs operated by NCHSR and for dissemination activities directly undertaken by NCHSR.

The Secretary is also required to obligate from funds appropriated under this section not less than \$4.5 million for each of fiscal years 1988 through 1990 for health care technology assessment activities. For the Council on Health Care Technology, the Secretary is required to make available from funds appropriated under this section not more than \$750,000 for each of the fiscal years 1988 through 1990. No more than \$1.5 million may be used for grants and contracts for all the costs of planning, establishing and operating centers (authorized under section 305(e)). The law also authorizes to be appropriated \$55 million for FY 1988, and such sums as may be necessary for each of fiscal years 1989 and 1990, for health statistical and epidemiological activities.

(z) *Additional definitions.*—No provision.

(aa) *Terminations.*—No provision.

(bb) *Contract for temporary assistance to Secretary for Health Care Technology Assessment.*—No provision.

(cc) *Technical and conforming amendments to the PHS Act.*—No provision.

(dd) *Transitional and savings provisions.*—No provision.

House bill

(a) *In general.*

Section 10154.—Adds a new section 1142 to title XI of the Social Security Act, entitled “Research and Education Concerning the Outcomes, Effectiveness, and Appropriateness of Medical Care.” Provides to the Secretary of HHS the responsibility for carrying out the research program.

Section 4111.—Adds a new section 1142, entitled “Research on Outcomes of Health Care Services and Procedures.” Places the responsibility for carrying out the research program with the Administrator of the Agency for Health Care Research and Policy, an agency that is required to carry out outcomes research in a manner consistent with the new section 1142 of the Social Security Act, which is established by the bill under a new title IX of the Public Health Service Act (see sections (m) and (n) below).

(b) Establishment of Research and Education Program

Section 10154.—Requires the Secretary to provide for outcomes, effectiveness, and appropriateness research with respect to specific medical treatment or specific medical conditions chosen using the selection procedure described (see section (j) below on “Coordinating Group”).

Requires this research to include: (a) a review of existing research findings with respect to treatment or conditions; (b) a review of the existing methodologies that use large data bases in conducting such research, and development of new research methodologies, including data-based methods of advancing knowledge and methodologies that measure clinical and functional status of patients; (c) grants and contracts to research centers, and contracts to other entities, to conduct research on treatment or conditions, including research on the appropriate use of prescription drugs; (d) development of projects to demonstrate the use of claims data and data on clinical and functional status of patients in determining the outcomes, effectiveness, and appropriateness of such treatment; and (e) supplementation of existing data bases, including the collection of new information, to enhance data bases for research purposes, and the design and development of new data bases that would be used in outcomes and effectiveness research.

Requires the Secretary to establish a process to assure that new information and medical innovation are addressed, in a timely manner, and incorporated into outcomes, appropriateness and effectiveness research when appropriate.

Section 4111.—Requires the Secretary, acting through the Administrator for Health Care Research and Policy, to conduct and support research with respect to the outcomes of health care services and procedures in order to identify the manner in which diseases, disorders, and other health conditions can most effectively and appropriately be diagnosed and treated.

Provides that the Administrator, in carrying out these responsibilities, conduct or support evaluations of the comparative effects, on health and functional capacity, of alternative services and procedures utilized in diagnosing and treating diseases, disorders, and other health conditions.

Provides that the Administrator conduct and support research with respect to improvement of the methodologies and criteria utilized in conducting research with respect to outcomes of health care services and procedures, and evaluations of methodologies that utilize large data bases (including claims data and clinical data) in conducting research with respect to such outcomes.

(c) Priority with respect to certain health conditions

Section 10154.—Provides that the medical conditions to be researched be selected by a Coordinating Group (composed of the Assistant Secretary for Health, the Assistant Secretary for Planning and Evaluation, and the Administrator of HCFA) but that at least 2/3 of the conditions have the concurrence of the HCFA Administrator (see section (j) below on "Coordinating Group").

Section 4111.—Requires the Administrator for Health Care Research and Policy to establish priorities with respect to the diseases, disorders, and other health conditions for which evaluations are to be conducted. Provides that in establishing such priorities, the Administrator is required to consider the extent to which: (a) improved methods of diagnosis and treatment can benefit a significant number of individuals; (b) there is significant variation among physicians in the particular services and procedures utilized in making diagnoses and providing treatments or there is significant variation in the outcomes of health care services or procedures due to different patterns of diagnosis or treatment; (c) the services and procedures utilized for diagnosis and treatment result in relatively substantial expenditures; and (d) the data necessary for such evaluations are readily available or can readily be developed.

Provides that for the purpose of establishing such priorities, the Administrator may, with respect to services and procedures utilized in diagnosing and treating diseases, disorders and other health conditions, conduct or support assessments of the extent to which: (a) rates of utilization vary among similar populations for particular diseases, disorders, and other health conditions; (b) uncertainties exist on the effect of utilizing a particular service or procedure; or (c) inappropriate services and procedures are provided.

(See section (i) below which provides for an Advisory Council to advise the Secretary and the Administrator regarding priorities for a national strategy for, among other things, the conduct of outcomes research under this section.)

(d) Standards for data bases

Section 10154.—Provides that to promote the research described above through the use of a wider data base, the Secretary is required to develop standards to be used in the collection and maintenance of data (whether by the Secretary or others). Requires that the Secretary, in developing these standards, develop (1) uniform definitions of data to be collected and used in describing a patient's clinical and functional status; (2) common reporting formats and linkages for such data; and (3) standards to assure the security, confidentiality, accuracy, and appropriate maintenance of such data. Requires the Secretary to report to Congress no later than one year after enactment on the feasibility of linking such research-related data of HHS with such data collected or maintained by other Federal departments (including the Departments of Defense and Veterans' Affairs and the Office of Personnel Management) and by non-Federal entities.

Sections 4111 and 4121.—Requires under title XI of the Social Security Act that the Administrator of the Agency for Health Care Research and Policy develop and promote the use of uniform stand-

ards and formats in the collection and maintenance of information on the outcomes of health care services and procedures, including the effect on health and functional capacity resulting from such services and procedures. (See also section (v) below.)

Amends the Public Health Service Act to require the Administrator of the Agency for Health Care Research and Policy to assure the utility of the data for all interested entities, and to establish guidelines for uniform methods of developing and collecting data. Requires the guidelines to include specifications for the development and collection of data on the outcomes of health care services and procedures.

(e) Dissemination of findings and education of providers

Section 10154.—Requires the Secretary to provide for the dissemination of findings of the research described in this section and for the education of providers and others in the application of the research. Requires in so doing that the Secretary develop: (1) a program designed to identify effective means to educate, and to educate physicians, other providers, consumers, and others in using the research findings, including a formal training program for training physician managers within provider organizations; and (2) appropriate relationships between the Department and professional associations, medical societies, and other relevant groups.

Section 4111.—Requires that the Administrator of Health Care Research and policy provide for the dissemination of the research findings and for the education of providers. Authorizes the Administrator to conduct or support research with respect to disseminating information and the effectiveness and appropriateness of health care services and procedures. Requires the Administrator to conduct and support evaluations of the activities carried out under the bill title to determine the extent to which such activities have had an effect on the practices of physicians in providing medical treatment, the delivery of health care, and the outcomes of health care services and procedures. (See also sections (q), (r) and (s) below relating to the "Forum for Quality and Effectiveness.")

(f) Development of practice guidelines

Section 10154.—Requires the Secretary to establish an on-going program of financial support and oversight to: (1) develop (based on research described above) treatment-specific or condition-specific practice guidelines for clinical treatments and conditions selected by the Coordinating Group (see section (j) below on the "Coordinating Group") in forms appropriate for use in clinical practice, educational programs, and in reviewing quality and appropriateness of medical care, and (2) to update such guidelines and forms to reflect changes in technology and appropriate medical practice.

Sections 4101 and 4111.—No provision under title XI of the Social Security Act. Section 4101 establishes the Office of the Forum for Quality and Effectiveness in Health Care under the Public Health Service Act. Requires the Director of the Office to arrange for the development and periodic review and updating of: (a) clinically relevant guidelines that may be used by physicians and health care practitioners to assist in determining how diseases, disorders, and other health conditions can most effectively and ap-

appropriately be diagnosed and treated; and (b) standards of quality, performance measures, and medical review criteria through which health care providers and other appropriate entities may assess or review the provision of health care and assure the quality of such care. Requires the Director to establish standards and criteria to be used by expert panels in the development and periodic review and updating of the guidelines. (See sections (q), (r), and (s) below.)

(g) Medicare demonstration project

Section 10154.—Requires the Administrator of HCFA to initiate by January 1, 1991, a demonstration project to evaluate the application of the practice guidelines to at least three clinical treatments or conditions that account for a significant portion of Medicare expenditures, and have a significant variation in the frequency or the type of treatment provided. Requires the Secretary to provide for an evaluation of the project as a model for broad scale implementation.

Sections 4101 and 4111.—No provision under title XI of the Social Security Act. Amends the Public Health Service Act to authorize the Director of the Office of the Forum to conduct or support pilot testing of the guidelines standards, performance measures, and review criteria. (See section (s) below.)

(h) Reports to Congress

Section 10154.—Requires the Secretary to report to Congress by February 1 of each year (beginning with 1991) on the progress of the activities under this part of the bill during the previous fiscal year, including the impact of such activities on medical care (particularly medical care for individuals receiving Medicare benefits). (See also section (d) on “Standards for Data Bases” regarding the required report on linking HHS data with data maintained by other departments.)

Section 4101 and 4111.—No provision.

(i) Advisory council

Section 10154.—Requires the Secretary to provide a charter for, and appointment of 18 members to, an advisory council to assist the Secretary in activities conducted under this part of the bill, including commenting and advising the Secretary regarding each annual coordination plan transmitted by the coordinating group (described below under section (j) on “Coordinating Group”). Provides that membership on the advisory council consist of representatives from a broad range of interested parties. Requires the Assistant Secretary of Health to be responsible for providing the advisory council with such staff and technical assistance as may be required. Provides that Section 14 of the Federal Advisory Committee Act does not apply to the advisory council.

Section 4111 and 4121.—No provision under title XI of the Social Security Act but establishes an Advisory Council for Health Care, Research, Evaluation and Policy under the Public Health Service Act. Specifies responsibilities, membership, appointment of a chair, time of meetings, compensation, and reimbursement of expenses, staff and duration. (See section (t) below on “Additional Duties of the Agency for Health Care Research and Policy.”)

(j) Coordinating group

Section 10154.—Requires the Secretary to establish a coordinating group composed of the Assistant Secretary for Health, the Assistant Secretary for Planning and Evaluation, and the Administrator of HCFA. Provides that the Assistant Secretary of Health serve as chairman of the coordinating group. Requires the coordinating group to: (1) transmit annually to the Secretary a plan to coordinate the activities of the Department in respect to research and education on outcomes, effectiveness and appropriateness of medical care; standards for data bases, dissemination of findings and education; and development of practice guidelines; (2) establish annually an agenda (including priorities) for activities under this section and periodically monitor and review activities conducted under this section (including coordination and information exchange); and (3) select the specific treatments and medical conditions to be the subject of research and guidelines for the research on outcomes effectiveness and appropriateness, and the development of practice guidelines, of which at least 2/3 must have the concurrence of the HCFA Administrator.

Section 4111.—No provision under title XI of the Social Security Act (see section (t) below on “Additional Authorities and Duties of the Agency for Health Care Research and Policy” relating to duties of the Advisory Council established under the Public Health Service Act.

(k) Authorization of appropriations

Section 10154.—Authorizes to be appropriated to carry out this section: (1) \$72 million for FY1990; (2) \$110 million for FY1991; (3) \$170 million for FY1992; (4) \$225 million for FY1993; and (5) \$270 million for FY1994. Authorizes that 2/3 of these amounts for any fiscal year are to be transferred to carry out this section in the following proportions from the following trust funds: (1) 60% from the Medicare Hospital Insurance Trust Fund and (2) 40% from the Medicare Supplementary Insurance Trust Fund. Provides that of the amounts transferred or otherwise appropriated to carry out this section in FY1990, 1/3 shall be allotted for research activities on outcomes, effectiveness and appropriateness, 1/3 for developing standards for data bases; 1/6 for dissemination of findings and education, to be distributed evenly between informational and educational activities; and 1/6 for the development of practice guidelines and the Medicare demonstration project.

Section 4111.—Authorizes to be appropriated \$8.3 million for FY1990, \$12.5 million for FY1991, and \$16.7 million for FY1992. In addition to these amounts, authorizes to be transferred from the Medicare Supplementary Trust Fund \$16.7 million for FY1990, \$25 million for FY1991, and \$33.3 million for FY1992.

(l) Definitions

Section 10154.—Defines “outcomes research” to mean, with respect to a medical condition, research that (1) focuses on the evaluation of a treatment or alternative treatments for the condition, and (2) formally assesses the probabilities for the full spectrum of different outcomes and the value of these outcomes for patients, in-

cluding mortality, morbidity, functional status, symptoms, and quality of life.

Defines “effectiveness research” to mean, with respect to a treatment, research that focuses on (1) the uses of the treatment for patients in typical clinical practice and the impact on outcome of the treatment of those patients, taking into account (to the extent relevant) patient conditions and local environment, and (2) through routine monitoring and feedback of information to physicians and patients, changes in the treatment to improve outcomes in such practice.

Defines “appropriateness research” to mean, with respect to a treatment, an assessment, which may be based on outcomes research, effectiveness research, or a consensus of medical experts or expert judgment, of the characteristics of particular patients for which the treatment is effective.

Section 4111.—Defines “Administrator” to mean the Administrator for Health Care Research and Policy. (See section (z) below on “Additional Definitions.”)

(m) Establishment of the Agency for Health Care Research and Policy

Section 10154.—No provision.

Section 4101.—Amends the Public Health Service Act by authorizing a new title IX—Agency for Health Care Research and Policy (AHCRP). Provides that the purpose of the Agency is to enhance the quality, appropriateness, and effectiveness of health care services, and access to such services, through the establishment of a broad base of scientific research and through improvements in clinical practice and in the organization, financing and delivery of health care services. Provides that the Agency be headed by the Administrator for Health Care Research and Policy to be appointed by the Secretary. Provides that the Secretary, acting through the Administrator, carry out the authorities and duties established in this new title IX of the Public Health Service Act.

(n) General authorities and duties of the agency

Section 10154.—No provision.

Section 4101.—(1) In general.—Requires the Administrator of the Agency for Health Care Research and Policy (AHCRP) to conduct and support research, demonstration projects, evaluations, training, and the dissemination of information, on health care services and on systems for the delivery of such services, including activities with respect to: (a) the effectiveness, efficiency, and quality of health care services; (b) subject to (4) below (requiring consistency with section 1142 of the Social Security Act) the outcomes of health care services and procedures; (c) clinical practice, including primary care and practice-oriented research; (d) health care technologies, facilities, and equipment; (e) health care costs, productivity and market forces; (f) health promotion and disease prevention; (g) health statistics and epidemiology; and (h) medical liability.

(2) Rural areas and underserved populations: Requires the Administrator of AHCRP to undertake and support research, demonstration projects, and evaluations in respect to (a) the delivery of health care services in rural areas (including frontier areas); and

(b) the health of low-income groups, minority groups, and the elderly.

(3) Multidisciplinary centers: Authorizes the Administrator of AHCRC to provide financial assistance to public or nonprofit private entities for meeting the costs of planning and establishing new centers, and operating existing and new centers for multidisciplinary health services research, demonstration projects, evaluations, training, policy analysis, and demonstrations in respect to rural areas and underserved populations.

(4) Relation to certain authorities regarding Social Security: Provides that activities required in this section may include, and should be appropriately coordinated with, experiments, demonstration projects, and other related activities authorized by the Social Security Act and the Social Security Act Amendments of 1967. Requires activities related to outcomes of procedures and surgeries to be carried out consistent with section 1142 of the Social Security Act (as created under this bill), relating to research and education on outcomes, effectiveness, and appropriateness of medical care (see sections (a) and (b) above).

(o) Dissemination by the Administrator of the Agency for Health Care Research and Policy

Section 10154.—No provision but see section (e) on “Dissemination of Findings and Education” above.

Section 4101.—(1) In general: Requires the Administrator of AHCRC to: (a) promptly publish, make available, and otherwise disseminate, in understandable form and on as broad a basis as practicable, the results of research, demonstration projects and evaluations conducted or supported under Title IX of the PHS Act (created by this bill); (b) promptly make available to the public data developed in such research, demonstration projects and evaluations; (c) provide indexing, abstracting, translating, publishing, and other services leading to a more effective and timely dissemination of information on research, demonstration projects, and evaluations with respect to health care to public and private entities and individuals engaged in the improvement of health care delivery and the general public, and undertake programs to develop new or improved methods for making such information available; and (d) as appropriate, provide technical assistance to State and local health agencies and conduct liaison activities to such agencies to foster dissemination.

(2) Prohibition against restrictions: Prohibits the Administrator of AHCRC from restricting the publication or dissemination of data from, or the results of, projects conducted or supported under title IX of the PHS Act, except as provided under subsection (3) as follows.

(3) Limitation on use of certain information: Prohibits the use of information for any purpose other than the purpose for which it has been supplied, if an establishment or person supplying the information or described in it is identifiable, unless the establishment or person has consented (as determined under regulations of the Secretary) to its use for such other purpose. Prohibits the publication or release in an other form if the person who has supplied the information or who is described in it is identifiable unless the

person has consented (as determined under regulations of the Secretary) to its publication or release in that other form.

(4) Certain interagency agreement: Provides that the Administrator of AHCRP and the Director of the National Library of Medicine enter into an agreement providing for the implementation of subsection (1)(c) above relating to indexing and other services.

(p) Health care technology and technology assessment

Section 10154.—No provision.

Section 4101.—(1) In general: Provides that the Administrator of AHCRP shall promote the development and application of appropriate health care technology assessments by: (a) identifying needs in, and establishing priorities for, the assessment of specific health care technologies; (b) developing and evaluating criteria and methodologies for health care technology assessment; (c) conducting and supporting research on the development and diffusion of health care technology; (d) conducting and supporting research on assessment methodologies; and (e) promoting education, training, and technical assistance in the use of health care technology assessment methodologies and results.

(2) Specific assessments: Requires the Administrator of AHCRP to conduct and support specific assessments of health care technologies. Requires the Administrator in respect to these assessments to consider the safety, efficacy, and effectiveness, and, as appropriate, the cost-effectiveness and appropriate uses of such health care technologies.

(3) Information center: Provides for the establishment of an information center on health care technologies and health care technology assessment at the National Library of Medicine. Requires the Administrator of AHCRP and the Director of the National Library of Medicine to enter into an agreement providing for the implementation of the information center.

(4) Recommendations with respect to health care technology: Requires the Administrator of AHCRP to make recommendations to the Secretary and to the Administrator of HCFA with respect to whether specific health care technologies should be reimbursable under federally financed health programs, including recommendations with respect to any conditions and requirements under which such reimbursements should be made. Requires the Administrator of AHCRP to consider the safety, efficacy, and, as appropriate, the cost-effectiveness and appropriate uses of such technology in making such recommendations. Requires the Administrator of AHCRP to cooperate and consult with the Director of NIH, the Commissioner of FDA, and the heads of any other interested Federal department or agency in carrying out this subsection.

(q) Establishment of the forum for quality and effectiveness in health care

Section 10154.—No provision.

Section 4101.—(1) Establishment of Office. Establishes within the Agency for Health Care Research and Policy an office to be known as the Office of the Forum for Quality and Effectiveness in Health Care. Requires the Administrator of AHCRP to appoint a Director to head the office.

(2) Duties: Requires the Administrator of AHCRP, acting through the Director, to establish a program known as the Forum for Quality and Effectiveness in Health Care. Requires the Director to arrange for the development and periodic review and updating of: (a) clinically relevant guidelines that may be used by physicians and health care practitioners to assist in determining how diseases, disorders, and other health conditions can most effectively and appropriately be diagnosed and treated; and (b) standards of quality, performance measures, and medical review criteria through which health care providers and other appropriate entities may assess or review the provision of health care and assure the quality of such care. Requires the director to do this using the process described below under section (r) below on "Forum of Experts and Consumers."

(3) Certain requirements: Requires that guidelines, standards, performance measures, and review criteria be based on the best available research and professional judgment regarding the effectiveness and appropriateness of health care services and procedures and be presented in formats appropriate for use by consumers of health care.

(4) Authority for contracts: Authorizes the Director to enter into contracts with public or nonprofit private entities in carrying out this subsection.

(r) Forum/panels of experts and consumers

Section 10154.—No provision.

Section 4101.—(1) Panels and contracts: Requires the Director of the Forum for Quality and Effectiveness in Health Care to convene panels of appropriately qualified experts (including practicing physicians) and health care consumers for the purpose of developing and periodically reviewing and updating the guidelines, standards, performance measures, and review criteria, and to enter into contracts with public and nonprofit private entities for this purpose.

(2) Authority for additional panels: Authorizes the Director to convene additional panels of appropriately qualified experts (including practicing physicians) and health care consumers for the purpose of: (a) making recommendations to the Director on priorities and strategies; (b) developing the standards and criteria; and (c) providing advice to the Administrator of AHCRP and the Director with respect to other specified activities carried out under the bill.

(3) Selection of panel members: Requires the Director in selecting the panels to consult with a broad range of interested individuals and organizations, including organizations representing physicians in the general practice of medicine and organizations representing physicians in specialties pertinent to the purposes of the panel involved. Requires the Director to appoint physicians reflecting a variety of practice settings.

(s) Additional requirements for the forum for quality and effectiveness

Section 10154.—No provision but see section (f) on "Development of Practice Guidelines" above.

Section 4101.—(1) Program agenda: Requires the Director to provide for an agenda for the development of the guidelines, standards, performance measures, and review criteria including identifying specific diseases, disorders, and other health conditions for which the guidelines are to be developed and those that are to be given priority in the development of the guidelines, and identifying specific aspects of health care for which the standards, performance measures and review criteria are to be developed and those that are to be given priority in the development of standards, performance measures and review criteria. Requires the Director to take into consideration the extent to which the guidelines, standards, performance measures, and review criteria can be expected to: (a) improve methods of diagnosis and treatment for the benefit of a significant number of individuals, (b) reduce clinically significant variations among physicians in the particular services and procedures utilized in making diagnoses and providing treatments; and (c) reduce clinically significant variations in the outcomes of health care services and procedures.

(2) Standards and criteria: Requires the Director to: (a) establish standards and criteria to be used by the expert panels in the development and periodic review and updating of the guidelines, standards, performance measures, and review criteria; (b) establish standards and criteria to be used for the purpose of ensuring that, if any contracts are entered into for the development or periodic review or updating of the guidelines, standards, etc, the contracts will be entered into only with appropriately qualified entities; (c) ensure that the standards and criteria specify that appropriate consultations with interested individuals and organizations are conducted in the development of the guidelines, standards, performance measures, and review criteria. Provides that such development may be accomplished through the adoption, with or without modification, of guidelines, standards, performance measures and review criteria that meet requirements and are developed by entities independently of the program established in this section; and (d) conduct and support research with respect to improving the standards and criteria.

(3) Dissemination: Requires the Director to promote and support dissemination of the guidelines, standards, performance measures and criteria. Requires the dissemination to be carried out through organizations representing health care providers, organizations representing health care consumers, peer review organizations, and other appropriate entities.

(4) Pilot testing: Authorizes the Director to conduct or support pilot testing of the guidelines, standards, performance measures, and review criteria. Provides that any such pilot testing may be conducted prior to, or concurrently with, their dissemination.

(5) Evaluations: Authorizes the Director to conduct and support evaluations of the extent to which the practice guidelines, standards, performance standards, and review criteria have had an effect on the clinical practice of medicine.

(6) Recommendations to the Administrator: Requires the Director to make recommendations to the Administrator on activities that should be carried out under this part of the bill and under the Social Security Act including recommendations of particular re-

search projects that should be done with respect to (1) evaluating the outcomes of health care services and procedures; (2) developing the standards and criteria required under the section (f) above on the "Development of Practice Guidelines"; and (3) promoting the utilization of the guidelines, standards, performance standards, and review criteria.

(t) Additional authorities and duties of the agency for health care research and policy

Section 10154.—No provision but see section (i) on "Advisory Council" above.

Section 4121.—(1) In general: Amends the PHS Act to establish an advisory council to be known as the National Advisory Council for Health Care Research, Evaluation and Policy.

(2) Duties of the advisory council: Requires the Council to advise the Secretary and the Administrator of AHCRP with respect to activities to carry out the purpose of the Agency. Requires the Council's activities to include making recommendations to the Administrator regarding priorities for a national agenda and strategy for: (a) the conduct of research, demonstration projects, and evaluations with respect to health care, including clinical practice and primary care; (b) the development and periodic review and updating of guidelines for clinical practice, standards of quality, and performance measures with respect to health care; (c) the development and application of appropriate health care technology assessments; and (d) the conduct of research on outcomes of health care services and procedures under the relevant section (section 1142 of title XI) of the Social Security Act.

(3) Membership of the council: Requires the Council to be composed of appointed members and ex officio members. Provides that all members are to be voting members. Requires the Administrator of AHCRP to appoint to the Council 15 appropriately qualified representatives of the public who are not officers or employees of the United States. Requires the Administrator of AHCRP to ensure that the appointed members, as a group, are representative of professions and entities concerned with, or affected by, activities under this title of the bill and under the relevant section (section 1142 of title XI) of the Social Security Act. Provides that of the members, 8 are to be individuals distinguished in the conduct of research, demonstration projects, and evaluations with respect to health care; 3 are to be individuals distinguished in the practice of medicine; 2 are to be individuals distinguished in the fields of business, law, ethics, economics, and public policy; and 2 are to be individuals representing the interests of consumers of health care.

(4) Ex officio members: Requires the Administrator of AHCRP to designate as ex officio members of the Council the Director of NIH, the Director of the CDC, the Administrator of HCFA, the Assistant Secretary of Defense (Health Affairs), the Chief Medical Officer of the Department of Veterans Affairs, and other Federal officials that the Administrator may consider appropriate for membership on the Council.

(5) Terms: Provides that, in general, Council members be appointed for a term of 3 years. Provides that of the members first appointed to the Council, the Secretary shall appoint 5 members to

serve for a term of 3 years, 5 members to serve for 2 years, and 5 to serve for 1 year.

(6) Vacancies: Provides that any member of the Council appointed to fill a vacancy occurring before the expiration of the term of the predecessor of the member is to be appointed for the remainder of the term of the predecessor. Provides that an appointed member of the Council may continue to serve after the expiration of the term of the member until a successor is appointed.

(7) Chair: Requires the Administrator of AHCRP to designate an individual to serve as chair from among the members appointed to the Council.

(8) Meetings: Requires the Council to meet not less than once during each 4-month period and to otherwise meet at the call of the chair.

(9) Compensation and reimbursement: (a) Appointed members: Provides that appointed members receive compensation for each day (including travel time) engaged in carrying out Council duties. Prohibits the compensation from exceeding the maximum rate of basic pay for GS-18 of the General Schedule; (b) Ex officio members: Provides that such members may not receive compensation for service on the Council in addition to the compensation otherwise received for duties carried out as officers of the United States.

(10) Staff: Requires the Administrator of AHCRP to provide to the Council such staff, information, and other assistance as may be necessary to carry out the duties of the Council.

(11) Duration: Requires the Council to continue in existence until otherwise provided by law.

(u) Peer review with respect to grants and contracts

Section 10154.—No provision.

Section 4121.—(1) Requirements of review: Requires that appropriate technical and scientific peer review be conducted with respect to each application for a grant, cooperative agreement, or contract under this title of the bill. Requires that each peer group to which an application is submitted report its finding and recommendations respecting the application to the Administrator of AHCRP in such form and in such manner as the Administrator requires.

(2) Approval as precondition of awards: Prohibits the Administrator of AHCRP from approving an application unless the application is recommended for approval by a peer review group established by (3) below.

(3) Establishment of peer review groups: Requires the Administrator of AHCRP to establish such technical and scientific peer review groups as may be necessary to carry out this section. Provides that such groups be established without regard to provisions of specified titles of Federal law relating to Federal employees. Requires that members of any peer group be appointed from among individuals who are not officers or employees of the United States and who by virtue of their training or experience are eminently qualified to carry out the duties of such peer review group. Provides that the peer review groups continue in existence unless otherwise provided by law.

(4) **Categories of review:** Requires that review of applications with respect to research, demonstration projects, or evaluations be conducted by different peer review groups than the groups that conduct such review or applications with respect to dissemination activities or the development of research agendas (including conferences, workshops, and meetings). Provides that in the case of applications for financial assistance whose direct costs will not exceed \$50,000, the Administrator of AHCRP may make appropriate adjustments in the procedures otherwise established by the Administrator for the conduct of peer review. Provides that these adjustments may be made for the purpose of encouraging the entry of individuals into the field of research, for the purpose of encouraging clinical practice-oriented research, and for other purposes the Administrator may determine to be appropriate.

(5) **Regulations:** Requires the Secretary to issue regulations for the conduct of peer review under this section.

(v) Provisions with respect to development, collection, and dissemination of data

Section 10154.—No provision but see section (d) on “Standards for Data Bases” above.

Section 4121.—(1) **Standards with Respect to Utility of Data:** Requires the Administrator of AHCRP to establish guidelines for uniform methods of developing and collecting data developed or collected by any entity for the purpose of enhancing quality, appropriateness, and effectiveness of health care services, as well as access to those services. Requires the guidelines to include specifications for the development and collection of data on the outcomes of health care services and procedures. (See also section (d) on “Standards for Data Bases” above.)

(2) Requires the Administrator of AHCRP to take such action as may be necessary to assure that statistics developed under this title are of high quality, timely, and comprehensive, as well as specific, standardized, and adequately analyzed and indexed. Requires the Administrator of AHCRP to publish, make available, and disseminate such statistics on as wide a basis as is practicable.

(w) Additional provisions with respect to grants and contracts

Section 10154.—No provision.

Section 4121.—(1) **Requirement of Application:** Prohibits the Administrator of AHCRP, in respect to any program under this title of the bill authorizing the provision of grants, cooperative agreements or contracts, from providing any financial assistance unless an application for the assistance is submitted to the Secretary and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Administrator determines to be necessary to carry out the program involved.

(2) **Provision of Supplies and Services in Lieu of Funds:** Provides that upon request of an entity receiving a grant, cooperative agreement, or contract, the Secretary is authorized to provide supplies, equipment and services for the purpose of aiding the entity in carrying out the project involved and, for such purpose, may detail to the entity any officer or employee of HHS. Provides that in such a

case, the Secretary is required to reduce the amount of the financial assistance involved by the amount equal to the costs of detailing personnel and the fair market value of any supplies, equipment, or services provided by the Administrator of AHCRP. Requires the Secretary to expend the amounts withheld for the payment of expenses in complying with such a request.

(x) Certain administrative authorities

Section 10154.—No provision.

Section 4121.—(1) Deputy Administrator and Other Officers and Employees: Permits the Administrator of AHCRP to appoint a deputy administrator for the agency. Permits the administrator to appoint and fix the compensation of such officers and employees as may be necessary to carry out this title. Provides that except as otherwise provided by law, the officers and employees are to be appointed in accordance with specified laws and their compensation fixed in accordance with title 5 of the U.S. Code (relating to the Federal civil service).

(2) Facilities: Permits the Secretary in carrying out this title to acquire by lease or otherwise through the Administrator of General Services, buildings or portions of buildings in the District of Columbia or communities located adjacent to D.C. for use for a period not to exceed 10 years, and to acquire, construct, improve, repair, operate, and maintain laboratory, research, and other necessary facilities and equipment, and such other real or personal property (including patents) as the Secretary deems necessary.

(3) Provision of Financial Assistance: Permits the Administrator of AHCRP, in carrying out this title, to make grants to, and enter into cooperative agreements with, public and nonprofit private entities and individuals, and, when appropriate, contracts with public and private individuals and entities.

(4) Utilization of Certain Personnel and Resources: Permits the Administrator of AHCRP to utilize personnel and equipment, facilities, and other physical resources of HHS, permit appropriate entities and individuals to use the physical resources of HHS, and provide technical assistance and advice. Permits the Administrator of AHCRP to use, with their consent, the services, equipment, etc. of other Federal, State, or local public agencies, or of any such foreign government, with or without reimbursement of such agencies.

(5) Consultants: Permits the Secretary to secure, from time to time and for such periods as the Administrator of AHCRP deems advisable but in accordance with specified law, the assistance and advice of consultants from the U.S. or abroad.

(6) Experts: Permits the Secretary to obtain the services of not more than 50 experts or consultants who have appropriate scientific or professional qualifications. Requires that the experts or consultants be obtained in accordance with specified Federal law, except that the limitation on the duration of service does not apply. Requires that the experts or consultants be reimbursed for their expenses associated with traveling to and from their assignment location in accordance with specified sections of Federal law. Provides that expenses may not be allowed in connection with the assignment of an expert or consultant unless he or she agrees in writing to complete the entire period of assignment, or one year,

whichever is shorter, unless separated or reassigned for reasons that are beyond his or her control and that are acceptable to the Secretary. Provides that if he or she violates the agreement, the money spent by the United States for expenses is recoverable as a debt to the United States. Permits the Secretary to waive in whole or in part a right of recovery.

(7) Voluntary and Uncompensated Services: Permits the Administrator of AHCRP to accept voluntary and uncompensated services.

(y) Funding of the Agency for Health Care Research and Policy

Section 10154.—No provision.

Section 4121.—(1) Authorization of Appropriations: Authorizes to be appropriated \$35 million for FY90, \$50 million for FY91, and \$70 million for FY92.

(2) Evaluations: Authorizes that in addition to amounts available pursuant to subsection (1) above, that amounts be made available to the Agency for Health Care Research and Policy equal to 40% of the maximum amount authorized for HHS evaluation funds.

(z) Additional definitions

Section 10154.—No provision.

Section 4121.—Defines the following terms as they apply to this title: (a) "Administrator" means Administrator for Health Care Research and Policy; (b) "Agency" means Agency for Health Care Research and Policy; (c) "Council" means the National Advisory Council on Health Care Research, Evaluation, and Policy; (d) "Director" means the director of the Office of the Forum for Quality and Effectiveness in Health Care.

(aa) Terminations

Section 10154.—No provision

Section 4131.—Abolishes NCHSR in HHS and all of its functions, including the duty to advise the Secretary on health care technologies. Repeals the Secretary's authority to conduct research, evaluation and demonstration projects through the Center on the following: (1) the accessibility, acceptability, planning, organization, distribution, technology, utilization, quality, and financing of health services and systems; (2) the supply and distribution, education and training, quality, utilization, organization and costs of health manpower; (3) the design, utilization, organization and cost of facilities and equipment; (4) the role of market forces in health care and their role in restraining cost increases and improving the availability and quality of care; and the safety, efficacy, effectiveness and cost effectiveness, economic, and social impacts of health care technologies.

Repeals the Secretary's authority to conduct research on health care delivery in rural areas. Eliminates mandate on the Secretary to assist State and local health agencies through a user liaison program and a technical assistance program. Repeals the mandate on the Secretary to assist, through grants or contracts, public or private nonprofit entities in meeting costs of planning and establishing new centers for multidisciplinary health services research,

evaluation, training, policy analysis and demonstrations regarding the Center's functions. Abolishes the Secretary's authority to undertake and support research regarding technology diffusion, methods to assess health care technology and specific health care technologies through the Center.

Abolishes the National Advisory Council on Health Care Technology Assessment and all of its functions, including the duty to advise the Secretary and the Director of the Center on health technology assessment functions.

Repeals the Secretary's authority to make grants for the planning, development, establishment and operation of a council on health care technology. Abolishes the council and its functions, including the following: (1) promotion of the development and application of appropriate health care technology assessment; and (2) review of existing health care technologies in order to identify obsolete or inappropriately used health care technologies.

(bb) Contract for temporary assistance to Secretary for Health Care Technology Assessment

Section 10154.—No provision.

Section 4132.—Requires the Secretary to request the Institute of Medicine of the National Academy of Sciences to enter into a contract: (1) to develop and recommend to the Secretary priorities for assessing specific health care technologies; and (2) to assist the Administrator for Health Care Research and Policy and the Director of the National Institute of Medicine in establishing the information center on health care technologies and health care technology assessment required under Section 904 of this bill. Requires the Secretary to assure that these two functions are completed not later than one year after the Secretary enters into the contract. Requires the Secretary of HHS to transfer to the Secretary [sic] any information and materials developed by the Council on Health Care Technology. Provides an appropriation of \$300,000 for FY 90 to carry out these functions.

(cc) Technical and conforming amendments to the PHS Act

Section 10154.—No provision.

Section 4133.—Makes miscellaneous technical and conforming amendments to the Public Health Service Act.

Amends section 306 of the PHS Act authorizing NCHS to require the Center to conduct and support statistical and epidemiological activities for the purpose of improving the effectiveness, efficiency, and quality of health services in the U.S. Authorizes appropriations of \$55 million for FY 1988 and such sums as may be necessary for each of FY 1989 and FY 1990.

(dd) Transitional and savings provisions

Section 10154.—No provision.

Section 4134.—Transfers personnel of HHS employed on the date of enactment in functions assigned to the Administrator of Health Care Research and Policy to the Administrator, along with assets, property, contracts, liabilities, records, unexpended balances of appropriations, authorizations, allocations or other funds connected with such functions. Specifies that unexpended funds transferred

can only be used for the purpose for which the funds were originally authorized and appropriated.

Specifies that all orders, rules, regulations, grants, contracts, certificates, license, privileges, and other determinations, actions or other official documents of HHS that have been issued, made, granted or allowed to become effective in performing functions assigned to the Administrator for Health Care Research and Policy and that are effective on enactment will continue in effect according to their terms unless changed by law.

Effective date

Section 10154.—Enactment.

Section 4135.—Effective October 1, 1989 or upon date of enactment, whichever occurs later.

Senate amendment

No provision.

Conference agreement

(a) *In general.*—The conference agreement includes section 4111 of the House provision with an amendment changing the name of the Agency to the Agency for Health Care Policy and Research.

(b) *Establishment of research and education program.*—The conference agreement includes section 4111 of the House provision with an amendment. Changes “diagnosed and treated” to “prevented, diagnosed, treated, and managed clinically” wherever it appears in this subsection of the bill. Also changes “diagnosing and treating” to “preventing, diagnosing, treating, and managing clinically” wherever it appears in this section of the bill. The conference agreement requires that the Secretary, in addition to conducting and supporting research with respect to outcomes, effectiveness, and appropriateness of health care, also assure that the needs and priorities of the Medicare program are appropriately reflected in the development and periodic review and updating (through the process set forth by this bill in section 913 of the Public Health Service Act relating to the development of guidelines and standards) of treatment-specific or condition-specific practice guidelines for clinical treatments and conditions in forms appropriate for use in clinical practice, for use in educational programs, and for use in reviewing quality and appropriateness of medical care.

In carrying out this requirement (and PHS requirements relating to the development of initial guidelines), the agreement requires that no later than January 1, 1991, the Secretary shall assure the development of an initial set of guidelines that includes not less than three clinical treatments or conditions that account for a significant portion of Medicare expenditures and have a significant variation in the frequency or the type of treatment provided, or otherwise meet the needs and priorities of the Medicare program as set forth under the subsection relating to priorities and their relationship to the Medicare program (see (c)). The Secretary is required to provide for the use of these guidelines to improve the quality, effectiveness, and appropriateness of care provided under Medicare. Requires the Secretary to determine the impact of such use on the quality, appropriateness, effectiveness, and cost of medi-

cal care provided under Medicare and to report to the Congress on such determination no later than January 1, 1993. For this purpose, the Secretary is required to expend \$1,000,000 for fiscal year 1990 and \$1,500,000 for each of fiscal years 1991 and 1992, 60 percent of which is to be appropriated from the Medicare Hospital Insurance Trust Fund and 40 percent is to be appropriated from the Medicare Supplementary Medical Insurance Trust Fund.

The conference agreement provides that with respect to the improvement of methodologies and criteria for evaluations, that: (1) the Secretary conduct and support research with respect to the improvement of methodologies and criteria; (2) conduct and support reviews and evaluations of existing research findings with respect to such treatment or conditions; (3) conduct and support reviews and evaluations of the existing methodologies that use large data bases in conducting such research and shall develop new research methodologies, including data-based methods of advancing knowledge and methodologies that measure clinical and functional status of patients, with respect to such research; (4) provide grants and contracts to research centers, and contracts to other entities, to conduct such research on such treatment or conditions, including research on the appropriate use of prescription drugs; (5) conduct and support research and demonstrations on the use of claims data and data on clinical and functional status of patients in determining the outcomes, effectiveness, and appropriateness of such treatment; and (6) conduct and support supplementation of existing data bases, including the collection of new information, to enhance data bases for research purposes, and the design and development of new data bases that would be used in outcomes and effectiveness research.

The conferees intend, that to the extent appropriate, the Secretary use the information and practice guidelines developed under the program to enhance the quality of care provided through titles XVIII and XIX of the Social Security Act. The Secretary shall also assimilate the research findings, practice guidelines and other information from this program to improve the efficiency and effectiveness of the Medicare and Medicaid programs.

The conferees intend that the research findings and guidelines developed under this program be reflected in the peer review, review of medical necessity, quality of care standards and provider certification, payment determinations, and other utilization review activities. Further, it is intended that the Secretary ensure that the research and guidelines programs be responsive to the needs and priorities that may arise from implementation of physician payment reform under this Act.

The conferees also intend that the research program shall provide for the development and use of appropriate methodologies for assessment of patient outcomes including experimental and nonexperimental methods. It is intended that the research program will use an array of scientifically valid research methodologies that reflect individual study needs for outcome data. The conferees also desire the Secretary to assess the feasibility, cost and appropriateness of using clinical trials, including trials investigating the role of patient preferences in carrying out the purposes of this section. It is anticipated that the Secretary may desire to use matching

funds in contract agreements for the development of practice guidelines. It is intended that the Secretary have the authority to do so in appropriate circumstances.

The conferees intend that in carrying out the conduct and support of research in this section, that the Secretary shall make available waivers of Medicare coverage rules for service provided under research protocols.

In addition, the conferees intend that for purposes of this provision, the term "clinical management" refers to the management of individual patient care and not the organizational management of the delivery of health care services.

(c) *Priorities with respect to certain health conditions.*—The conference agreement includes section 4111 of the House provision with an amendment. Requires the Secretary to establish the priorities, and provides that research as well as evaluations are to be conducted or supported. Permits the Secretary to conduct or support assessments. Provides that in establishing priorities for research and evaluation (and under the Public Health Service Act provision created by this bill relating to the program agenda of the Forum for Quality and Effectiveness), the Secretary is required to assure that such priorities appropriately reflect the needs and priorities of the Medicare program, as set forth by the Administrator of HCFA.

(d) *Standards for data bases.*—The conference agreement includes section 10154 of the House provision with modifications. Requires that the report on research-related data include the feasibility of linking such data with similar data collected by non-Federal (as well as Federal) entities. The conferees do not intend that these standards have to apply to data bases already established and in use.

(e) *Dissemination of findings and education of providers.*—The conference agreement includes sections 10154 and 4111 with modifications. Under section 10144, the conference agreement provides for the dissemination of the initial guidelines described in subsection (b) above. Requires the Secretary to work with professional associations, medical specialty and subspecialty organizations, and other relevant groups to identify and implement effective means to education physicians, other providers, consumers, and others in using such findings and guidelines, including training for physician managers within provider organizations. Under section 4111 relating to evaluations, the conference agreement requires the Secretary to conduct and support evaluations. Under section 4111 relating to research with respect to dissemination, permits the Secretary to conduct or support such research.

(f) *Development of practice guidelines.*—No provision.

(g) *Medicare demonstration project.*—No provision but see (n).

(h) *Reports to Congress.*—The Conference Agreement includes section 10154 of the House provision with modifications. Requires the Secretary to report to Congress no later than February 1 of each of the years 1991 and 1992, and of each second year thereafter, on the progress of the activities under this section during the preceding fiscal year (or preceding two fiscal years, as appropriate).

(i) *Advisory council.*—The conference agreement includes section 4121 of the House provision with an amendment (see (t) below).

(j) *Coordinating group.*—No provision.

(k) *Authorization of appropriations.*—The conference agreement includes section 10154 of the House provision with an amendment. Authorizes to be appropriated to carry out this section: \$50 million for FY 1990; \$75 million for FY 1991; \$110 million for FY 1992; \$148 million for FY 1993; and \$185 million for FY 1994. Authorizes that $\frac{2}{3}$ of the amounts for fiscal years 1990 through 1992, and 70 percent for fiscal years 1993 and 1994 be transferred to carry out this section in the following proportions from the following trust funds: (1) 60 percent from the Medicare Hospital Insurance Trust Fund, and (2) 40 percent from the Medicare Supplementary Medical Insurance Trust Fund.

The conference agreement provides that for each fiscal year, of the amounts transferred or otherwise appropriated to carry out this section, the Secretary is required to reserve appropriate amounts for each of the following purposes: (1) the development of guidelines, standards, performance measures, and review criteria; (2) research and evaluation; (3) data-base standards and development; and (4) education and information dissemination.

(l) *Definitions.*—No provision.

(m) *Establishment of the Agency for Health Care Research and Policy.*—The conference agreement includes section 4101 of the House provision with an amendment changing the name of the Agency to the Agency for Health Care Policy and Research.

(n) *General authorities and duties of the agency.*—The conference agreement includes section 4101 of the House provision with an amendment. Adds guideline development to the activities that the Administrator is required to do. Under the section on "relation to certain authorities regarding Social Security," the conference agreement changes "activities required" to "activities authorized." Requires that activities relating to the outcomes of health care services and procedures that affect the Medicare and Medicaid programs be carried out consistent with section 1142 of the Social Security Act (as created under this bill).

(o) *Dissemination by the Administrator of the Agency for Health Care Research and Policy.*—The conference agreement includes section 4101 of the House provision with an amendment. Requires the Administrator to promptly publish, make available, and otherwise disseminate, in an understandable form and on as broad a basis as practicable so as to maximize its use, the results of research, demonstration projects, and evaluations. Requires the Administrator to provide technical assistance to State and local government and health agencies.

(p) *Health care technology and technology assessment.*—The conference agreement includes section 4101 of the House provision with an amendment. Requires the Administrator to make recommendations to the Secretary and not to the Secretary and the Administrator of HCFA with respect to whether specific health care technologies should be reimbursable. Requires that the Administrator consider the safety, efficacy, and effectiveness, and, as appropriate, the cost-effectiveness, legal, social, and ethical implications, and appropriate uses of technologies, including the consideration of geographic factors.

(q) *Establishment of the forum for quality and effectiveness in health care.*—The conference agreement includes section 4101 of the House provision with an amendment. Adds that guidelines, standards, performance measures and review criteria include treatment-specific or condition-specific practice guidelines for clinical treatments and conditions in forms appropriate for use in clinical practice, for use in educational programs, and for use in reviewing quality and appropriateness of medical care. Requires the Administrator, no later than January 1, 1991, to assure the development of an initial set of guidelines, standards, performance measures, and review criteria that includes not less than three clinical treatments or conditions described in section 1142(a)(3) of the Social Security Act (as created by this section) relating to initial guidelines. Requires that to assure an appropriate reflection of the needs and priorities of the Medicare program, activities under this part that affect the Medicare program are to be conducted consistent with section 1142 of that Act (as created by this section).

(r) *Forum/panels of experts and consumers.*—The conference agreement includes section 4101 of the House provision with an amendment. Changes the process by which guidelines and standards are to be developed. Requires the Director of the Forum to enter into contracts with public and nonprofit private entities for the purpose of developing and periodically reviewing and updating the guidelines, standards, performance measures, and review criteria. Includes under the role of the panels the reviewing of the guidelines, standards, performance measures and review criteria developed under the contracts with public and nonprofit private entities. Under “authority” for additional panels,” specifies that the practicing physicians be ones with appropriate expertise, and eliminates the role of panels in making recommendations to the Director on priorities and strategies. Under “selection of panel members,” adds organizations representing physicians in subspecialties.

(s) *Additional requirements for the forum for quality and effectiveness.*—The conference agreement includes section 4101 of the House provision with an amendment. Changes the “Director” to the “Administrator.” Requires that in providing for the program agenda, including priorities, the Administrator must consult with the Administrator of HCFA and otherwise act consistent with the provision of 1142 of the Social Security Act (as created by this bill) specifying the relationship of the research program on outcomes and effectiveness with the Medicare program. Under “standards and criteria,” provides that the Director establish standards and criteria to be utilized by the recipients of the contracts and by the expert panels.

(t) *Additional authorities and duties of the Agency for Health Care Research and Policy.*—The conference agreement includes section 4121 of the House provision with an amendment. Under the duties of the council, deletes reference to section 1142 of the Social Security Act. Under “membership,” requires the Secretary to appoint the members of the Council, and ensure that they are representative.

Membership of the council.—Requires the Council to be composed of appointed members and ex officio members. Provides that all appointed and five ex officio members, as identified in statute, are to

be voting members. Requires the Administrator of the AHCPR to appoint to the Council 17 appropriately qualified representatives of the public who are not officers or employees of the United States. Requires the Administrator of AHCPR to ensure that the appointed members, as a group, are representative of professions and entities concerned with, or affected by, activities under this title of the bill and under the relevant section (section 1142 of title XI) of the Social Security Act. Provides that of the members, 8 are to be individuals distinguished in the conduct of research, demonstration projects, and evaluations with respect to health care; 3 are to be individuals distinguished in the practice of medicine; 2 are to be individuals distinguished in the health professions; 2 are to be individuals distinguished in the fields of business (which could include medical device manufacturing), law, ethics, economics, and public policy; and 2 are to be individuals representing the interests of consumers of health care.

Ex officio members.—Requires the Administrator of AHCPR to designate as ex officio voting members of the Council the Director of NIH, the Director of CDC, the Administrator of HCFA, the Assistant Secretary of Defense (Health Affairs), the Chief Medical Officer of the Department of Veterans Affairs. Allows the Administrator to appoint as nonvoting ex officio members such other Federal officials as the Secretary may consider appropriate.

The conference agreement also requires the Secretary to establish a Subcouncil on Outcomes and Guidelines to make recommendations regarding priorities for a national agenda and strategy for carrying out the development and periodic review and updating of guidelines and the conduct of outcomes research. Requires the Secretary to designate the membership of the subcouncil as follows: (1) six individuals from among the individuals appointed to the Advisory Council from the following groups: individuals appointed to the Advisory Council from the following groups: individuals distinguished in the conduct of research, demonstration projects and evaluations with respect to health care, those distinguished in the practice of medicine, and those distinguished in the health professions; (2) two individuals from among the individuals appointed to the Council from those distinguished in the fields of business, law, ethics, economics, and public policy and those individuals representing the interests of consumers of health care; (3) the following officials designated as ex officio members of the Advisory Council: the Director of the National Institutes of Health, the Director of the Centers for Disease Control, the Administrator of HCFA, the Assistant Secretary of Defense (Health Affairs), and the Chief Medical Officer of the Department of Veterans Affairs.

(u) *Peer review with respect to grants and contracts.*—The conference agreement includes section 4121 of the House provision.

(v) *Provisions with respect to development, collection, and dissemination of data.*—The conference agreement includes section 4121 of the House provision with an amendment. Adds that the Secretary must, in order to assure the accuracy and sufficiency (as well as utility) of the data, establish guidelines. Adds that in any case where the guidelines for uniform methods of developing and collecting data may affect the administration of the Medicare pro-

gram, the guidelines must be in the form of recommendations to the Secretary for the Medicare program.

(w) *Additional provisions with respect to grants and contracts.*—The conference agreement includes section 4121 of the House provision.

(x) *Certain administrative authorities.*—The conference agreement includes section 4121 of the House provision.

(y) *Funding for the Agency for Health Care Research and Policy.*—The conference agreement includes section 4121 of the House provision.

(z) *Additional definitions.*—The conference agreement includes section 4121 of the House provision.

(aa) *Terminations.*—The conference agreement includes section 4131 of the House provision.

(bb) *Contract for temporary assistance to Secretary of Health Care Technology Assessment.*—The conference agreement includes section 4132 of the House provision.

(cc) *Technical and conforming amendments to the Public Health Service Act.*—The conference agreement includes section 4133 of the House provision with an amendment.

(dd) *Transitional and savings provisions.*—The conference agreement includes section 4134 of the House provision with an amendment.

Effective date

Enactment.

PART D—MEDICARE PART B BASIC PREMIUM

1. Part B Premium

Section 10161 of House bill; section 5401 of Senate amendment.

Present law

Ordinarily, the law sets the basic Part B premium rate as the lower of: (a) an amount sufficient to cover one-half of the costs of the program for the aged; or (b) the previous year's premium increased by the percentage increase in Social Security cash benefit payments.

For the period 1984-1989, the Congress approved a series of amendments which set the premium equal to 25 percent of program costs for the aged. The calculation reverts to the earlier method in 1990.

House bill

Sets the basic Part B premium at 25 percent of program costs for the aged in 1990.

Effective date

Enactment.

Senate amendment

Identical provision.

Effective date

Enactment.

Conference agreement

The House and Senate provision was adopted.

2. Limitations on Charges for Medicare Beneficiaries Eligible for Medicaid Benefits

Section 4025 of House bill.

Present law

Prior to the enactment of the 1988 Medicare Catastrophic Coverage Act, some Medicare beneficiaries also met state Medicaid income and asset requirements, and were eligible for both Medicare and Medicaid. This group is known as dual eligibles. Current law does not explicitly require mandatory assignment of Medicare claims for dual eligibles, but that has been the practical effect because physicians are not permitted to bill Medicaid beneficiaries for services.

The 1988 Medicare Catastrophic Coverage Act expanded Medicaid eligible to a larger group of Medicare beneficiaries based on higher income and asset tests. This group is known as qualified Medicare beneficiaries. Physicians treating qualified Medicare beneficiaries are not required to bill on an assignment related basis.

House bill

Requires physicians providing services to beneficiaries who are dually eligible for Medicare and Medicaid (including as a qualified Medicare beneficiary) to accept assignment for these claims. Subjects physicians who knowingly and willfully balance bill to exclusion from Medicare or civil monetary penalties, or both.

Effective date

Applies to services furnished on or after January 1, 1990.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the provisions of the House bill with modifications.

**PART E—EXTENSION OF COBRA CONTINUATION COVERAGE FOR
DISABLED EMPLOYEES**

1. Extension of COBRA Continuation Coverage from 18 to 29 Months for Those with a Disability at Time of Termination of Employment

Section 10171 of the House bill. •

Present law

(a) *In general.*—Under Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA, P.L. 99-272), employers with 20 or more employees are required to provide certain employees and their families the option of purchasing continued health insurance coverage in the case of certain events. These events include: termination or reduction in hours of employment, death, divorce or legal separation, eligibility for Medicare, or the end of a child's dependency under a parent's health insurance policy. The maximum period of continuation coverage that may be elected is 36 months except in the case of termination of employment or reduction of hours for which the maximum period is 18 months. COBRA continuation coverage may be terminated before the maximum 18 or 36 months in the case of certain events. These include: the employer ceases to provide any group health plan to any employee, the beneficiary fails to pay the premium, or the qualified beneficiary becomes covered under another group health plan or entitled to Medicare.

(b) *Increased premium permitted.*—Employers are currently allowed to charge qualified beneficiaries 102 percent of the applicable premium for continuation coverage.

(c) *Notices required.*—Title X of COBRA requires that qualified beneficiaries notify the employer's plan administrator in the case of certain events.

House bill

(a) *In general.*—Amends section 4980(B)(f) of the Internal Revenue Code (providing for continuation coverage requirements of group health plans). Provides that in the case of a qualified beneficiary who is determined under title II (OASDI) or XVI (SSI) of the Social Security Act to have been disabled at the time of the qualifying event of termination of employment or reduction in hours of employment, the beneficiary is entitled to 29 (as opposed to 18) months of continuation coverage, but only if the qualified beneficiary has provided notice of such determination before the end of the 18 months. Provides that the extended continuation of coverage can be terminated in the month that begins more than 30 days after the date of the final determination under title II or title XVI of the Social Security Act that the qualified beneficiary is no longer disabled.

(b) *Increased premium permitted.*—Amends the law to allow employers to charge 150 percent of the applicable premium for the eleven additional months of coverage provided to disabled beneficiaries provided by this section.

(c) *Notices required.*—Amends the notice requirements of Title X of COBRA to require that each qualified beneficiary who is determined under title II or title XVI of the Social Security Act to have been disabled at the time of a qualifying event (termination of employment or reduction in hours of employment) is responsible for notifying the plan administrator of such determination within 60 days after the date of the determination and for notifying the plan administrator within 30 days of the date of any final determination that the qualified beneficiary is no longer disabled.

Effective date

Effective for plan years beginning on or after the date of enactment, regardless of whether the qualifying event occurred before, on, or after such date.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House provision..

PART F—REVISIONS TO THE MEDICARE CATASTROPHIC COVERAGE ACT OF 1988

The conferees agreed to delete from the bill all provisions related to Medicare catastrophic coverage, and to resolve those issues in H.R. 3607, the “Medicare Catastrophic Coverage Repeal Act of 1989.”

Subtitle C—Human Resource Amendments

A. Social Services

1. INCREASE FUNDING FOR THE TITLE XX SOCIAL SERVICES BLOCK GRANT

Section 10201 of House bill.

Current law

Under Title XX of the Social Security Act States are entitled to receive social services block grant funds. These funds must be used to provide services directed at achieving five goals: preventing or reducing dependency; achieving self-sufficiency; preventing or remedying neglect, abuse or exploitation of children and adults; preventing or reducing inappropriate institutional care; and providing services or referrals to individuals in institutions.

Title XX is a capped entitlement; funds are currently limited to \$2.7 billion annually. The share for each State is based on its relative share of the national population.

House bill

The entitlement ceiling for the Title XX social services block grant would be increased by \$200 million in fiscal year 1991, \$400 million in fiscal year 1992, and \$600 million in fiscal year 1993 and thereafter. These funds would not be earmarked, and are in addition to the Title XX earmark for child care. (The ceiling would be \$2.9 billion in FY 91, \$3.1 billion in FY 92, and \$3.3 billion thereafter, without taking into account the earmark for child care.)

Effective date

On enactment.

Senate amendment

No provision.

Conference agreement

The conference agreement would permanently increase the entitlement ceiling for the Title XX social services block grant by \$100 million beginning for fiscal year 1990. These funds would not be earmarked.

*B. Foster Care and Child Welfare Amendments***1. INCREASE IN CHILD WELFARE AUTHORIZATION**

Section 10211 of House bill.

Current law

Title IV-B of the Social Security Act authorizes the appropriation of Federal funds for child welfare services. These funds may be used for preventing or remedying neglect and abuse, preventing the separation of children from their families, reunifying families, placing children for adoption, and assuring adequate care for children in out-of-home placements. The authorization level for the Title IV-B child welfare services program is \$266 million per fiscal year.

Under the Title IV-B program, if total Federal appropriations exceed \$141 million in any fiscal year, a State may receive its portion of the funds in excess of \$141 million only if it has met the requirements for foster care protections outlined in section 427(a). In addition, if appropriations equal or exceed \$266 million for 2 consecutive years, a State may receive its share of appropriations in excess of the 1979 funding level (\$56.6 million) only if it has met the requirements for foster care protections outlined in section 427(b).

House bill

Increases the authorization level of the child welfare services program from \$266 million to \$400 million a year.

Increases from \$266 million to \$400 million the Title IV-B funding level at which, if equaled or exceeded for two consecutive years, a State must meet the requirements of section 427(b) in order to: (1) receive its share of the Federal appropriation for Title IV-B in excess of the 1979 funding level, and (2) transfer funds from the Title IV-E to the Title IV-B program.

Effective date

October 1, 1989.

Senate amendment

No provision.

Conference agreement

The conference agreement increases the authorization level of the child welfare services program from \$266 million to \$325 million a year.

The conference agreement also increases from \$266 million to \$325 million the title IV-B funding level at which, if equaled or exceeded for two consecutive years, a State must meet the require-

ments of section 427(b) in order to: (1) receive its share of the Federal appropriation in excess of the 1979 funding level; and (2) transfer funds from the Title IV-E to the Title IV-B program.

2. EXTENSION OF AUTHORITY TO TRANSFER FOSTER CARE FUNDS

Section 10212 of House bill.

Current law

Mandatory State-by-State ceilings are placed on foster care funds if the Federal appropriation for child welfare services reaches a specified trigger level, currently \$266 million. In the absence of a mandatory foster care ceiling, States may elect to operate under a voluntary ceiling. A State may use one of several methods to calculate the most favorable ceiling.

Under a voluntary ceiling, a State may transfer a portion of its unused foster care funds. However, the amount transferred, together with the State's IV-B allocation, may not exceed what the State would have received if the child welfare services appropriation had triggered the ceiling (i.e., currently \$266 million).

The foster care ceilings and the authority to transfer foster care funds to child welfare services expired September 30, 1989.

House bill

Extends the foster care ceilings and the authority to transfer foster care funds to child welfare services for three years, through September 30, 1992.

Permanently increases the Title IV-B child welfare services appropriations level at which a mandatory foster care ceiling is triggered from \$266 million to \$400 million.

Effective date

October 1, 1989.

Senate amendment

No provision.

Conference agreement

The conference agreement extends the foster care ceilings and the authority to transfer foster care funds to child welfare services for three years, through September 30, 1992.

The conference agreement permanently increases the Title IV-B child welfare services appropriations level at which a mandatory foster care ceiling is triggered from \$266 to \$325 million.

3. REQUIREMENT FOR STATE REPORT TO COURTS ON PREVENTIVE SERVICES

Section 10213 of House bill.

Current law

Currently, State child welfare agencies are not required to provide information to the courts, in order to assist them in carrying out their child welfare services functions.

House bill

Effective beginning fiscal year 1990, requires that the State child welfare agency compile on an annual basis a detailed report which specifies which preplacement preventive and reunification programs and services are operating and available to children and families in need in the State.

The report would include the following information: the name of the program and the administering agency or organization, the monthly number of persons the program is capable of serving, a description of program services, a description of eligibility for the services, and the location of services, as of August of the fiscal year.

The information in the report would be arranged geographically to correspond with the relevant court jurisdictions. Requires that by October 1 of the following fiscal year, a copy of the report must be provided to all judges and other judicial administrators, and all State agencies, involved in child protective services, and to the HHS Secretary. Requires that the HHS Secretary publish an annual summary of the State reports by January 1.

Effective date

October 1, 1989.

Senate amendment

No provision.

Conference agreement

House recedes.

4. INCREASE FEDERAL REIMBURSEMENT FOR FOSTER AND ADOPTIVE PARENT TRAINING

Section 10214 of House bill.

Current law

Federal matching funds for administrative expenditures for foster care and adoption assistance under Title IV-E are available at the rate of 50 percent. Current HHS regulations specify that foster and adoptive parents and staff of licensed or approved child care institutions providing foster care under Title IV-E are eligible for short-term training at the initiation of or during their provision of care, and that certain of the costs associated with such training (travel and per diem) may be reimbursed as administrative costs under Title IV-E.

House bill

Effective beginning fiscal year 1990, allows Federal reimbursement for foster and adoptive parent training under Title IV-E at the rate of 75 percent. In addition to travel and per diem, reimbursable activities would include the short-term training of current and prospective foster and adoptive parents and the staff of licensed or approved child care institutions providing care to foster and adoptive children receiving Title IV-E foster care maintenance

payments, in ways that increase their ability to provide support and assistance to Title IV-E foster and adopted children.

Effective date

Applies to expenditures made on or after October 1, 1989.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill, except the increased Federal reimbursement for foster and adoptive parent training would apply to expenditures made during the period extending from October 1, 1989 through September 30, 1992.

5. REQUIRE HEALTH AND EDUCATION RECORDS IN THE CHILD'S CASE
PLAN

Section 10215 of House bill.

Current law

Under present law, for each child receiving foster care maintenance payments under the responsibility of the State, a written case plan must be developed which includes a description of the home or institution in which the child is to be placed, a discussion of the appropriateness of the placement and a plan for assuring that the child receives proper care and that services are provided. These case plans must be reviewed every six months.

Additionally, in order to certify compliance with the requirements of section 427, a State must, in addition to other requirements, have a written case plan and provide a case review system for each child receiving foster care under the responsibility of the State.

House bill

Effective beginning fiscal year 1990, requires that a foster child's case plan include a record of his educational and health status. The record must indicate the following information, to the extent the information is available and accessible:

The names and addresses of the child's health and educational providers;

The child's grade level performance;

The child's school record;

Assurances that the child's placement in foster care takes into account proximity to the school in which the child is enrolled at the time of placement;

A record of the child's immunizations,;

The child's known medical problems;

The child's medications;

In the case of a Medicaid-eligible foster child, an indication that the child has received, within 60 days of placement in foster care and periodically thereafter, comprehensive health examinations that are identical to the assessments required by the State under the Early and Periodic Screening Diagnosis

and Treatment (EPSDT) program under Medicaid, as well as the results of the examinations and any follow-up treatment provided; and

Any other relevant health and education information concerning the child determined to be appropriate by the State agency.

The health and education record must be reviewed and updated at the time of each placement of a foster child in foster care.

The health and education record must be supplied to the foster parent or foster care provider with which the child is placed.

Effective date

October 1, 1989.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill, except that it excludes the provision requiring that the health and education record indicate that the foster child has received EPSDT exams and follow-up treatment. The provision would take effect on April 1, 1990.

6. INDEPENDENT LIVING PROGRAM

Section 10216 of House bill.

Current law

The Budget Reconciliation Act of 1985 established the independent living initiatives program, a State entitlement program under Title IV-E, to help States provide services in fiscal years 1987 and 1988 to facilitate the transition of Title IV-E foster children ages 16 and over to independent living. The Technical and Miscellaneous Revenue Act of 1988 extended the independent living program through fiscal year 1989, and expanded it to apply, at State option, to all children ages 16 and over in foster care, including those who are not receiving AFDC foster care payments. It was also expanded to apply for up to 6 months after foster care payments or foster care ends for children whose care or payments ended on or after they became age 16.

Independent living program services may include those that enable participants to seek a high school diploma or take part in vocational training; provide training in daily living skills, budgeting, locating housing and career planning; provide for counseling; coordinate services; establish outreach programs; and provide an independent living plan in the participant's case plan.

The entitlement funding level is set at \$45 million a year. Funds are allocated on the basis of the State's relative share of the number of children in Federally funded foster care in 1984.

House bill

Expands the purpose of the independent living program. The expanded program, called the Foster Care Adolescent Services Block

Grant, would be authorized for three years beginning in fiscal year 1990. The program would provide special services to adolescents in foster care, including the independent living services currently authorized. States could expend unobligated prior year funds in any of the three fiscal years for which the program is authorized. The entitlement level of the program would be increased to \$100 million annually.

In addition, at State option, eligibility for the program would be extended to youths in foster care who are age 10 or older. However, of the funds authorized for the Foster Care Adolescent Services Block Grant, each State would be required to expend at least 70 percent for independent living services for foster children ages 16 and older.

Payments under the program could be used to establish, extend and/or strengthen services and programs which focus on the needs of adolescents in foster care. In addition to independent living activities, such services and programs could include those which encourage and support school attendance, prevent alcohol and other drug abuse, increase access to mental health services and alcohol and drug abuse treatment, as well as other adolescent services determined to be appropriate by the State.

Effective date

October 1, 1989.

Senate amendment

No provision.

Conference agreement

The conference agreement would extend the current law independent living initiatives program through fiscal year 1992. The entitlement ceiling for the program would be increased to \$50 million for fiscal year 1990, \$60 million for fiscal year 1991, and \$70 million for fiscal year 1992. Beginning for fiscal year 1991, States would be required to provide 50 percent matching for any Federal funding claimed that exceeds the present \$45 million funding level.

The Department of Health and Human Services would be required to evaluate the effectiveness of the program, including a comparison of outcomes for youth participating in the program with similar youths who did not.

Payments to the States for this program could not be used to supplant other State or local funds.

Effective date

On enactment.

7. DATA COLLECTION

Section 10217 of House bill.

Current law

HHS is not required to develop an annual report on Federal expenditures, services and participation under the various Title IV-E and Title IV-B child welfare, foster care and adoption programs. In

addition, HHS does not collect and report comprehensive State-by-State data on the numbers, characteristics and status of children and families receiving Title IV-B and Title IV-E child welfare, foster care and adoption services and benefits, and of other children placed in foster care and adoption under the responsibility of the State child welfare agency.

The 1986 Budget Reconciliation Act included an amendment mandating certain studies and reports to Congress related to the feasibility of establishing a system for the collection of certain foster care and adoption data. The amendment, section 479 of the Social Security Act, required the Secretary of HHS to establish an Advisory Committee on Adoption and Foster Care Information. On October 1, 1987, the Advisory Committee submitted to the Congress the results of a study which identified the types of data necessary to assess on a continuing basis the incidence, characteristics and status of adoption and foster care. The advisory committee report recommended that the data collection system cover all legalized adoptions, including relative and non-relative adoptions, as well as adoptions under private and public auspices. With respect to foster care, the report called for data on all children within the purview of section 427 of the Social Security Act (relating to foster care protections), including children placed under the auspices of public child welfare agencies, children placed by private agencies under contract to the public agency, and children placed privately by licensed private agencies.

On May 26, 1989, the Secretary of HHS submitted to Congress a report, due on July 1, 1988, proposing a method of establishing, administering and financing a system for the collection of data relating to adoption and foster care in the United States. The report recommended limiting the scope of the system for adoption to only those adoptions in which the State child welfare agency is involved. With respect to foster care, it did not include the advisory committee's recommendation that the system require reporting for children placed privately by licensed private facilities. HHS is next required to promulgate final regulations providing for the implementation of the information system, with the full implementation of the system no later than October 1, 1991.

House bill

(a) *New data requirements.*—Amends section 479 to require the collection of additional information on foster care and adoption, including:

Separately for the Title IV-B child welfare services program, the Title IV-E foster care program, the Title IV-E adoption assistance program, and the Title IV-E Foster Care Adolescent Services Block Grant:

By State, a breakdown of total expenditures for the reporting period according to Federal dollars and State and local dollars;

By State, a breakdown of total Federal expenditures for the reporting period according to service categories established by the Secretary (who must consider the categories used in the Voluntary Cooperative Information System (VCIS) data collection system, those established by the Sec-

retary pursuant to P.L. 100-485 for the Title XX program, and the ability of the States to collect and report data by service category); and

By State, the number of persons during the reporting period (or average monthly number of persons, where appropriate) who received services, total and according to the service categories established by the Secretary;

A State breakdown for the reporting period on transfer of funds from the Title IV-E foster care program to the Title IV-B child welfare services program;

Foster care ceilings (allotments) by State under the Title IV-E foster care program;

The average monthly rate of payment, by State, for foster care maintenance, including information on special rates of payment and information, by State, on the cost of providing foster care incurred by foster care providers with whom the State contracts to provide such care;

Information by State regarding compliance with section 427 child welfare protections as of September 30 of the reporting period;

Information on the date and result of all title IV-E and title IV-B HHS compliance reviews and fiscal reviews, and any other such reviews undertaken;

Information for the reporting period regarding disallowances resulting from compliance and fiscal reviews, and any other such reviews undertaken; and

Any other data the Secretary deems necessary to monitor the operations of the child welfare programs under titles IV-B and IV-E.

(b) Promulgation of regulations.—Requires that no later than four months after the enactment of this legislation, the Secretary of HHS shall publish a notice of proposed rulemaking for the implementation of the data collection system required pursuant to section 479 of the Social Security Act, as amended, based on: the recommendations of the Advisory Committee on Adoption and Foster Care Information, the May 26, 1989 report of the Secretary to Congress required pursuant to section 479, and the Voluntary Cooperative Information System. The public must have 60 days to comment on the proposed regulations. No later than four months after the close of the comment period, the HHS Secretary shall publish final regulations. The regulations must provide for the full implementation of the system no later than October 1, 1991.

(c) Timing of the report.—Requires that the Secretary report to the Committee on Ways and Means and the Committee on Finance, on an annual basis by the last day of the calendar year; the foster care and adoption information collected pursuant to section 479, as amended by this legislation. The data in the report would be based on the preceding Federal fiscal year. To the extent prior year data are available, requires that it be included in the report. The annual report must include any explanatory text and notes necessary to interpret and evaluate the data included in the report. The first report would be due December 31, 1992.

(d) Interim reports.—Requires that the Secretary prepare interim reports due December 31, 1990 and December 31, 1991. These re-

ports would include any data required by section 479, as amended by this legislation, that is provided to the Secretary in time for such reports.

(e) Child abuse data collection.—Requires that the Secretary, through the National Center on Child Abuse and Neglect, collect and analyze aggregate and case-specific data on child abuse and neglect until the Secretary implements a new system (required by section 6 (b) (1) of the Child Abuse Prevention and Treatment Act) for identifying and reporting on child abuse and neglect. The child abuse and neglect reports must be issued at least biennially. The first report, containing 1987 and 1988 data, would be due no later than the end of calendar year 1990.

Effective date

On enactment.

Senate amendment

No provision.

Conference agreement

House recedes.

8. REVIEW OF STATE COMPLIANCE WITH CHILD WELFARE REQUIREMENTS

Section 10218 of the House bill.

Current law

Public Law 96-272, the Adoption Assistance and Child Welfare Amendments of 1980, provided financial incentives to States to implement and operate a set of services and procedures designed to prevent the unnecessary removal of children from their home, prevent extended stays in foster care and ensure that efforts are made to reunify children with their families or place them for adoption. The services and procedures are outlined in section 427 of the Social Security Act.

In fiscal year 1981, HHS requested that States "self-certify" their compliance with the section 427 protections "on the basis of their understanding of the statutory requirements and an analysis of the related State child welfare programs, systems and policies implemented and in operation during the year for which they certified (HHS Section 427 Review Handbook, August 1988, p. 1)." States which self-certified were to be reviewed later by the Department to ensure that they had actually implemented the section 427 protections.

According to the HHS Section 427 Review Handbook, to verify compliance with section 427 requirements, HHS conducts a two-stage review. The first stage is an administrative review which determines whether States have developed policy and procedures to implement the section 427 requirements for all children in foster care under the responsibility of the State. The second stage of the review is the case record survey which confirms that the policies are being implemented throughout the State.

An initial review is conducted for the fiscal year in which the State first certifies its eligibility. If a State meets the initial review,

a subsequent review is conducted for the following fiscal year. States that meet the requirements of this subsequent review will be reviewed for the third fiscal year following the fiscal year for which the subsequent review was conducted. This is known as the triennial review. The case record survey must confirm the section 427 foster care protections are provided for at least 66% of the children in the initial review; 80% in the subsequent review; and 90% in the triennial review. If a State does not meet the established standards for the year under review, the review is conducted each succeeding year until eligibility is established.

Final regulations implementing section 427 became effective on June 22, 1983.

House bill

(a) *Development of new review system.*—By March 1, 1990, the Secretary shall publish final rules which provide the specific, comprehensive set of standard criteria against which State programs will be uniformly measured for compliance with the section 427 protections.

Effective for any section 427 compliance review initiated for fiscal year 1991 or subsequent fiscal years, all HHS section 427 compliance review guidelines and all other materials used in the compliance review process, including instruments, methodology and forms, must conform to the revised regulations. In addition, no compliance review for fiscal year 1991 or later may be conducted using any guidelines and review materials that were revised less than six months prior to the beginning of the fiscal year under review.

(b) *Review timetable.*—No later than the beginning of fiscal year 1993, the Secretary shall have conducted a review of each State program under the new review system and shall have determined, based on the published standards, whether the program has been during the fiscal year under review in accordance with applicable section 427 requirements. Not less often than every three years (or not less often than annually in the case of any State which has been found in the most recent review to have been out of compliance) the Secretary shall conduct a complete review of the program in each State and determine, based on the published standards, whether the program has been operated during the fiscal year under review in accordance with applicable section 427 requirements.

Any State which is found to be out of compliance with the requirements of section 427 under the new system must receive final notification of any finding of noncompliance within forty-five working days of the review. Such notification must include the basis for the finding of noncompliance.

A State which is found through a review under the new system not to be in full compliance with the requirements shall be determined to be in substantial compliance only if the Secretary determines that any noncompliance with the requirements is of a technical nature which does not adversely affect program performance. These terms must be defined in the regulations.

(c) *Corrective action requirements.*—Any payments reduced or withheld as a result of a finding of noncompliance shall be sus-

pending for any fiscal year, beginning with fiscal year 1991, if the State (1) submits a corrective action plan, within a period prescribed by the Secretary, which contains steps necessary to achieve substantial compliance within a time period prescribed by the Secretary, (2) the plan is approved by the Secretary, and (3) the Secretary finds that the corrective action plan is being fully implemented by the State and that the State is progressing in accordance with the timetable contained in the plan to achieve substantial compliance.

Under the new system the Secretary shall rescind any reduction or withholding of payments if the State achieves substantial compliance in accordance with the timetable contained in the approved corrective action plan.

(d) Treatment of triennial reviews under current regulations.—Effective June 9, 1989, the Secretary of HHS would be permanently precluded from reducing any payments to, seeking repayment from or withholding any payments from any State under Titles IV-B or IV-E of the Social Security Act, as a result of a disallowance determination made in connection with a triennial review of State compliance with the foster care protections outlined in section 427 of the Social Security Act for any Federal fiscal year preceding fiscal year 1991.

Effective date

On enactment.

Senate amendment

No provision.

Conference agreement

The conference agreement provides that the Secretary of Health and Human Services could not, before October 1, 1990, reduce any payment to, seek any repayment from or withhold any payment from any State under Title IV-B or IV-E of the Social Security Act, as a result of a disallowance determination made in connection with a triennial review of State compliance with the foster care protections outlined in section 427 of the Social Security Act for any Federal fiscal year preceding fiscal year 1991.

C. Supplemental Security Income

1. OUTREACH PROGRAM FOR DISABLED AND BLIND CHILDREN

Section 10221 of House bill.

Current law

Current law has no specific provision dealing with outreach programs. However, the Social Security Administration (SSA) conducts national, regional, and local outreach and public information campaigns to reach individuals who may be eligible for SSI. SSA is continuing to establish liaisons with national, State, and local legal and welfare agencies and advocacy groups to inform them about the SSI program and to enlist their assistance in finding potentially eligible persons.

House bill

Establishes a permanent SSI outreach program for disabled and blind children. Requires the Secretary of Health and Human Services (HHS) to report annually on the effectiveness of this program and specifies the information which must be included in each report. Requires the Secretary to aim outreach efforts at populations for whom it would be most effective. Such efforts must include cooperation with other agencies and organizations which serve and have knowledge of potential recipients of SSI.

Effective date

On enactment.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill except that it excludes the requirement for annual reports by the Secretary. The provision will take effect 3 months after the date of enactment.

2. STANDARDS AND PROCEDURES FOR DETERMINING DISABILITY OF CHILDREN

a. Individual functional assessments of children

Section 10222 of House bill.

Current law

A medically determinable physical or mental impairment of comparable severity to that which would be considered disabling for an adult is required for children under 18 years old to be determined disabled. A child must have an impairment that meets or equals in severity an impairment in the Listing of Impairments in the regulations. This listing consists of Parts A and B. Part B contains impairments of children under 18. These criteria are applied first. If these are not met or equalled, then Part A criteria are applied.

Under Part A, an adult must be unable to engage in substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or to last at least 12 months. If the severity of an adult's impairment does not meet or equal the severity of an impairment in the Listings, he can still be found disabled if his impairment prevents him from doing any substantial gainful work that exists in the national economy, considering his vocational factors (age, education and work experience). This vocational test is not applied to children because they have no significant work histories.

Recently the Third Circuit Court of Appeals handed down an opinion requiring the Administration to institute a "functional assessment" step in the evaluation process for children. Three other circuit court opinions have upheld the Administration's procedures. The issue has been accepted for appeal by the Supreme Court and will likely be argued and decided next year.

House bill

Requires the Secretary of HHS, in determining SSI eligibility for the blind or disabled, to assess individually each child's mental and physical impairments, including functional limitations that interfere with the activities of daily living appropriate to the age of the child. In determining the extent to which the impairments prevent or interfere with age appropriate daily living activities, the Secretary shall evaluate the degree of support and intervention reasonably required.

Effective date

Applies to determinations made on or after October 1, 1989.

Senate amendment

No provision.

Conference agreement

House recedes.

b. Presumptive disability based on genetic or congenital impairments for children under 4 years old

Section 10223 of House bill.

Current law

To be eligible for SSI disability benefits, children born with genetic or congenital impairments must have impairments that meet or equal the severity of the impairments in the Listing of Impairments in regulations.

House bill

Requires the Secretary to presume a child under age 4 with a genetic or congenital impairment is disabled if the medical severity of the impairment cannot be accurately determined by clinical or laboratory techniques because the child is too young, and the Secretary determines that it is probable that, when the child is older, medical professionals will be able to administer a test that accurately demonstrates that the child suffers from an impairment or impairments of sufficient medical severity to qualify the child for benefits. This presumption may be rebutted. Such impairments must include but are not limited to cystic fibrosis, Down's syndrome, junctional epidermolysis bullosa, Hirschprung's syndrome, Tourette syndrome, Prader Willi syndrome, and spina bifida.

Effective date

October 1, 1989.

Senate amendment

No provision.

Conference agreement

House recedes.

c. Revised listings of impairments for children

i. Secretary Required to Publish Notice of Proposed Rulemaking on Revised Childhood Listings of Mental Impairments

Section 10224 of House bill.

Current law

At the request of SSA, a work group of psychiatrists and other specialists in children's disabilities developed revised standards for determining SSI eligibility for children with mental impairments. The work group reported on April 1, 1986. Proposed regulations to revise the mental listings were published on August 14, 1989.

House bill

Requires the Secretary of HHS to publish a notice of proposed rulemaking on the "Revised Childhood Listings of Mental Impairments" within 60 days after the date of enactment with final regulations issued nine months after enactment. The listings should be based on those submitted by the Mental Impairments Listing Workgroup of the Associate Commissioner for Disability on April 1, 1986.

Effective date

On enactment.

Senate amendment

No provision.

Conference agreement

House recedes.

ii. Require Revised Listings of Impairments for Children

Section 10225 of House bill.

Current law

Current "Listings of Impairments for Children" were published in 1977 in response to congressional pressure to develop appropriate standards for evaluating impairments of children. Although SSA is currently reviewing certain Listings, only limited changes have actually been made since 1977.

House bill

Requires the Secretary to solicit advice from childhood disability experts on changes that should be made to the children's "Listings of Impairments" so that they account for medical and functional rules that are appropriate to the age of the child. Requires publication of proposed revisions for public comment within 18 months from the date of enactment. Regulations must be final 24 months after the date of enactment.

Effective date

On enactment.

Senate amendment

No provision.

Conference agreement

House recedes.

3. ELIGIBILITY FOR RECIPIENTS WITH WEEKLY OR BIWEEKLY INCOME

Section 10226 of House bill.

Current law

An individual's initial eligibility for SSI in a month is determined on the basis of the individual's income, resources and other relevant factors in such month. The income is determined based on a projection of income for that month. The projected income is reconciled in later months with actual income as it is reported.

The amount of the SSI benefit in a month is determined on the basis of income and other factors in the first, or if the Secretary determines, second month preceding such month. Generally, the Secretary uses income and other factors in the second preceding month to determine the SSI benefit amount.

Individuals who earn biweekly or weekly income will occasionally receive 3 or 5 paychecks in a month instead of the usual 2 or 4 paychecks. The extra income in these months can make such individuals ineligible for SSI and Medicaid in these months. Such individuals are placed in a suspension status for that month and usually resume receiving benefits in the next month. When SSI benefits are suspended, Medicaid is terminated.

House bill

Requires the Secretary to deem certain individuals eligible for SSI benefits for the purpose of retaining Medicaid eligibility as long as they would be eligible for SSI benefits otherwise. An individual must meet three conditions: (1) the individual receives earned income on a regular weekly or biweekly basis; (2) the individual is determined to be ineligible for SSI for the month because of an extra weekly or biweekly paycheck; and (3) the individual would be eligible for SSI if the amount of his earned income in such month were equal to his average monthly rate of pay.

Effective date

Applies to benefits for months after September 1989.

Senate amendment

No provision.

Conference agreement

House recedes.

4. SSI BENEFITS FOR DISABLED CHILDREN OF PARENTS OVERSEAS

Section 10227 of House bill.

Current law

SSI benefits are paid only to individuals who live in the United States.

House bill

Extends eligibility for SSI benefits to disabled children who reside with parents working overseas. The child must be a U.S. citizen.

Effective date

Applies to benefits for months after September 1989.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill with an amendment limiting the provision to disabled children who reside with a parent who is a member of the U.S. Armed Forces assigned to permanent duty ashore outside the U.S., and who during the month prior to the parent's assignment abroad were receiving SSI disability benefits. The provision will take effect after March 1990.

5. WAIVER OF SSI INCOME AND RESOURCE DEEMING RULES FOR CERTAIN SEVERELY DISABLED CHILDREN

Section 10228 of House bill.

Current law

Under the SSI program, the income and resources of a disabled child's parents are "deemed" to the child if the child is living at home. These deeming rules do not apply if the child is hospitalized.

The Social Security Act authorizes States to offer programs so that disabled children can be cared for at home while retaining Medicaid eligibility. Under these programs, for purposes of Medicaid eligibility, the income and resource deeming rules do not apply.

House bill

Waives the SSI income and resource deeming rules in the case of severely disabled children who were eligible for SSI benefits while in a medical institution and who qualify for Medicaid under a State "home care" plan authorized under title XIX. For purposes of the SSI program, such children would receive the same personal needs allowance (\$30 per month) as if they were hospitalized.

Effective date

January 1, 1990.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill. The effective date will be the first day of the sixth calendar month beginning after the date of enactment.

6. INTERGENERATIONAL DEMONSTRATION PROJECT FOR DISABLED CHILDREN

Section 10229 of House bill.

Current law

No provision.

House bill

Authorizes the Secretary of Health and Human Services to conduct demonstration projects in 10 communities. The demonstrations would test the use of volunteer senior aides to provide basic medical assistance and support to families with moderately or severely disabled or chronically ill children. The demonstration would determine the contribution of such voluntary assistance to the reduction of the costs of care for these children.

Effective date

October 1, 1989.

Senate amendment

No provision.

Conference agreement

Senate recesses.

7. SSI BENEFIT INCREASE

Section 10241 of House bill.

Current law

The 1989 Federal SSI benefit standard for an individual and a couple is \$368 and \$553 per month, respectively.

House bill

Increases SSI benefits by \$2 per month for individuals and \$3 per month for couples.

Effective date

January 1, 1990.

Senate amendment

No provision.

Conference agreement

House recesses.

8. OUTREACH PROGRAM FOR ADULTS

Section 10242 of House bill.

Current law

Current law has no specific provision dealing with outreach programs. However, the Social Security Administration (SSA) conducts national, regional, and local outreach and public information campaigns to reach individuals who may be eligible for SSI. SSA is continuing to establish liaisons with national, State, and local legal and welfare agencies and advocacy groups to inform them about the SSI program and to enlist their assistance in finding potentially eligible persons.

House bill

Establishes a permanent SSI outreach program for adults. Requires the Secretary of Health and Human Services (HHS) to report annually on the effectiveness of this program. Requires the Secretary to aim outreach efforts at populations for whom it would be most effective. Such efforts should include not only ongoing efforts to notify social security beneficiaries of possible eligibility for SSI, but other efforts aimed at those not receiving social security.

Effective date

On enactment.

Senate amendment

No provision.

Conference agreement

House recedes.

9. TREATMENT OF INCOME IN SHARED LIVING ARRANGEMENTS

Section 10244 of House bill.

Current law

An individual living in another's household and receiving in-kind support and maintenance from the person in whose house he resides has his eligibility and benefits under SSI determined using a benefit rate that is reduced from the full Federal benefit rate by one-third. This is in lieu of including the actual value of the support and maintenance in his income.

Under regulations, the one-third reduction applies whenever an individual lives in the household of another unless: (1) all others in the household receive public assistance benefits; (2) the individual does not receive both food and shelter from within the household; or (3) the individual pays a pro rata share of the household's operating expenses.

If an individual is living with others and is not subject to the one-third reduction or is the owner of the house, regulations provide for determining whether the individual is receiving in-kind assistance from someone in the household. If he is receiving assistance, it is presumed to have a value of one-third of the Federal benefit rate plus \$20 (the unearned income disregard) unless he shows SSA that the value of what he receives is less. The effect of the presumed maximum value is to reduce the benefit of the recipient by an amount equal to the one-third reduction.

House bill

In determining an individual's income, the Secretary must count the lesser of the actual value of in-kind assistance received by individuals or the current law one-third of the SSI benefit against the SSI benefit. Requires the Secretary to study the effect this provision has on SSI beneficiaries and the administration of the program and to report to Congress not later than 2 years after the date of enactment.

Effective date

Applies to benefits for months after December 1989.

Senate amendment

No provision.

Conference agreement

House recedes.

10. EXCLUSION FROM INCOME OF DOMESTIC COMMERCIAL
TRANSPORTATION TICKETS RECEIVED AS GIFTS

Section 10245 of House bill.

Current law

Domestic commercial transportation tickets received as gifts by SSI recipients are treated as unearned income and valued at their current market value unless the ticket is not convertible to cash (e.g., charged on the donor's credit card), in which case it is not counted as income.

House bill

Gifts of domestic commercial transportation tickets given to an individual or eligible spouse, which are used by that individual or spouse and not converted to cash, would be disregarded in determining their income.

Effective date

October 1, 1989.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill. The provision will be effective the first day of the third calendar month beginning after the date of enactment.

11. REDUCTION IN TIME DURING WHICH INCOME AND RESOURCES OF
SEPARATED COUPLES MUST BE TREATED AS JOINTLY AVAILABLE

Section 10246 of House bill.

Current law

A husband and wife who are aged, blind, or disabled, and who have not been living apart from each other for more than 6 months

are considered to be an eligible couple under SSI. If the couple separates, the spouses are considered to be a couple for SSI purposes until they have lived apart for more than 6 months.

House bill

A married couple would be treated as separate individuals for the purposes of determining eligibility and benefit amounts under SSI beginning after the first full month of their living apart. The Secretary could waive the one month period in an emergency.

Effective date

October 1, 1989.

Senate amendment

No provision.

Conference agreement

The conference agreement includes a provision under which a married couple would be treated as separate individuals for purposes of SSI eligibility and benefit determination beginning with the first month following the month of separation or, in any case in which either spouse files an application for benefits or requests restoration of eligibility, at the time the application or request is filed. The effective date is October 1, 1990.

12. EXCLUSION OF INTEREST AND ACCRUALS ON BURIAL SPACES FROM
RESOURCE LIMITS

Section 10247 of House bill.

Current law

A burial fund with a value of up to \$1,500 including interest on the fund, is excluded in determining whether an individual meets the SSI resources test. Burial spaces are also excluded, but interest on the spaces is not excluded except under specified conditions.

House bill

In determining income for purposes of SSI eligibility, interest and other accruals on burial spaces would be excluded.

Effective date

October 1, 1989.

Senate amendment

No provision.

Conference agreement

The conference agreement includes a provision requiring that, in determining income and resources for purposes of SSI eligibility, interest and other accruals on burial spaces must be excluded. The effective date will be the fourth month beginning after the date of enactment.

13. SPECIAL SSI BENEFITS FOR SOCIAL SECURITY DISABILITY INSURANCE (SSDI) RECIPIENTS WHO BECOME INELIGIBLE FOR SSDI BECAUSE OF EARNINGS

Section 10248 of House bill.

Current law

A basic test used in determining whether an individual is disabled for purposes of Social Security Disability Insurance (SSDI) or for SSI disability benefits is whether the individual has earnings that constitute performance of "substantial gainful activity" (SGA). If he does, he cannot qualify for benefits. The Secretary of HHS has defined SGA as earnings of \$300 a month. New regulations provide for increasing the SGA limit to \$500 a month beginning in January.

In order to allow disabled SSI recipients to return to work without facing a severe disincentive, the Congress enacted legislation creating "special status" benefits under section 1619 of the Social Security Act. Section 1619 allows SSI recipients who continue to be disabled, but who, despite their impairments, begin to work at earnings above the SGA level, to continue to receive "special" SSI cash benefits. The benefit amount is reduced as earnings rise. Medicaid benefits are also continued.

Different rules apply with respect to Social Security disability beneficiaries who return to work at earnings above the SGA level. In the DI program, an individual may work without having his earnings affect his benefits during a 9-month trial work period. After the trial work period, disability benefits stop if the individual engages in SGA. However, the individual is entitled to receive a social security benefit for any month in which he does not perform SGA in the 36-month period that begins after the month in which the trial work period ends.

A Social Security disability insurance beneficiary who loses SSDI benefits because his earnings exceed the SGA level cannot subsequently qualify for regular SSI benefits (because he does not meet the basic disability definition). He therefore also cannot qualify for "special status" benefits under section 1619 which are available only to individuals who first qualify for regular SSI benefits.

House bill

Permits an individual whose SSDI benefits cease (after the close of the individual's trial work period) because of work activity and who could be eligible for SSI but for the fact that he continues to engage in substantial gainful activity and, therefore, cannot establish initial eligibility for SSI disability benefits, to become eligible for cash and Medicaid benefits under section 1619. The individual must file an application for benefits during a 33-month period beginning with the first month after the end of the individual's trial work period for which a benefit is not payable, and would be deemed to have been eligible for SSI in the month immediately preceding such 33-month period.

Effective date

Applies to individuals whose trial work period ends after June 1990.

Senate amendment

No provision.

Conference agreement

House recedes.

**14. EXCLUSION OF VICTIMS' COMPENSATION PAYMENTS FROM SSI
INCOME AND ASSETS DETERMINATIONS**

Section 10249 of House bill.

Current law

Under current law, amounts received from victim assistance funds are included as income or assets for purposes of determining eligibility and benefits for SSI.

House bill

Any payment, or portion thereof, received from a State-administered victim assistance fund, that the beneficiary could demonstrate was compensation for expenses incurred or losses suffered as a result of the crime, would not be included as income or assets for purposes of determining SSI eligibility and benefits.

Any portion of a victim assistance payment which does not compensate for expenses incurred or losses suffered as a result of the crime, would not be counted as income for the month in which it is received. However, such portion, to the extent it is not expended during the nine-month period beginning after the month in which it was received, would be counted as a resource in the tenth month following the month in which it was received.

No person awarded victims' compensation, who was otherwise eligible for SSI and who refused to accept such compensation, would be considered ineligible for SSI as a result of such refusal.

Effective date

October 1, 1989.

Senate amendment

No provision.

Conference agreement

House recedes.

**15. EXCLUSION OF THE VALUE OF INCOME-PRODUCING PROPERTY FROM
EQUITY VALUE OF PROPERTY**

Section 10230 of House bill.

Current law

Excludes from being counted as a resource income producing property which is so essential to the means of self-support of the individual as to warrant its exclusion.

The exclusion (known as the \$6,000/6% rule) is limited by regulation to \$6,000 of an individual's equity in income-producing property and applies only if such property produces a net annual income to the individual of at least 6 percent of the excluded equity.

In cases where income produced by property essential to self-support meets the regular definition of earned income, it is counted as earned income. In all other cases it is counted as unearned income.

House bill

Requires that the value of property which is used in the person's trade or business, or in the employment of a family member, be excluded from the equity value of the person's property. Income generated from the property would be counted in determining eligibility and benefits.

Effective date

October 1, 1989.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill. The effective date will be the first day of the fifth calendar month beginning after the date of enactment.

D. Child Support Enforcement

1. EXTENSION OF IRS INTERCEPT FOR NON-AFDC FAMILIES

Sections 10231 and 10232 sections of House bill.

Current law

States may collect child support arrearages of at least \$500 owed to non-AFDC families through the Federal income tax refund offset mechanism. A similar mechanism is authorized for AFDC families, but the limit on arrearages is set at \$150 by regulations. The arrearages must be owed to a "minor child."

House bill

Extends for five years (through calendar year 1995) present law that allows States to request that the Internal Revenue Service (IRS) collect child support arrearages of at least \$500 out of income tax refunds due to non-custodial parents.

Retains current law requirements that the arrearage must be at least \$500 to qualify for intercept.

Eliminates the minor child restriction on court-ordered arrearages in non-AFDC child support cases under the income tax refund offset for adults with a current support order who are disabled, as defined under OASDI or SSI.

Effective date

Date of enactment for extension with expiration on January 10, 1996; January 1, 1990 for disabled child provision.

Senate amendment

No provision.

Conference agreement

House recedes.

2. MEDICAID TRANSITION IN CHILD SUPPORT CASES

Section 10233 of House bill.

Current law

Medicaid benefits continue for 4 months after a family loses AFDC eligibility as a result of collection of child support payments under Title IV-D of the Social Security Act. (Title IV-D authorizes the Child Support Enforcement (CSE) program.) This provision expired on October 1, 1989.

House bill

Makes permanent the requirement that Medicaid benefits continue after a family loses AFDC eligibility as a result of collection of child support payments under the IV-D program. Extends these benefits for 12 months after a family leaves AFDC due to collection of child support.

Effective date

October 1, 1989.

Senate amendment

No provision.

Conference agreement

The conference agreement permanently extends current law.

E. Unemployment Compensation

1. OPTIONAL BENEFITS FOR NON-PROFESSIONAL SCHOOL EMPLOYEES

Section 10261 of House bill.

Current law

States are required to deny eligibility for Unemployment Compensation to nonprofessional employees of educational institutions between academic years or terms. Before the Social Security Amendments of 1983, States had the option to provide such benefits.

House bill

Allows States the option of paying unemployment compensation to nonprofessional employees of educational institutions between academic terms or years.

Effective date

On enactment.

Senate amendment

No provision.

Conference agreement

House recedes.

2. PROHIBITION ON COLLATERAL ESTOPPEL

Section 10262 of House bill.

Current law

Currently, 14 States prohibit courts from using quasi-judicial decisions reached in Unemployment Compensation hearings to stop law suits on related employment issues, such as wrongful discharge from a job. This judicial doctrine is called, "collateral estoppel." Federal law has no provision.

House bill

Requires State Unemployment Compensation laws to prohibit courts from stopping law suits on related employment issues based on a decision made in an unemployment compensation hearing.

Effective date

Generally, October 1, 1989.

Senate amendment

No provision.

Conference agreement

House recedes.

3. SELF-EMPLOYMENT DEMONSTRATION PROJECTS

Section 10264 of House bill.

Current law

The Omnibus Budget Reconciliation Act of 1987 authorized a demonstration project under which up to 3 States would continue paying unemployment benefits to unemployed persons who attempt to set up their own businesses. In order to participate in a self-employment project, States would have to guarantee that no net additional costs in any fiscal year would accrue to the unemployment program as a result of the projects. (State general revenues would have to be used to meet administrative costs and to make up any losses to the unemployment compensation program.)

House bill

Authorizes appropriations totaling \$1 million to cover State administrative expenses for operating self-employment demonstration projects authorized by the Omnibus Budget Reconciliation Act of 1987.

Effective date

On enactment.

Senate amendment

No provision.

Conference agreement

House recesses.

4. WITHHOLDING UNEMPLOYMENT BENEFITS TO RECOUP UNPAID
UNEMPLOYMENT TAXES

Section 5601 of Senate amendment.

Current law

Federal law requires that amounts in State unemployment compensation accounts may be expended only for the purpose of paying unemployment benefits. The Department of Labor has held that the withholding of unemployment benefits to recoup unpaid unemployment taxes constitutes an improper use of the funds in the State unemployment account.

House bill

No provision.

Senate amendment

Federal rules governing allowable uses of funds in the State accounts of the Unemployment Trust Fund would be modified to allow States to deduct from the unemployment benefits otherwise payable to an individual any amounts the individual owes to the fund as unpaid unemployment taxes.

Effective date

On enactment.

Conference agreement

Senate recesses.

F. Aid to Families With Dependent Children

1. QUALITY CONTROL

a. Resolve the backlog of disallowances through FY90

Section 10271 of House bill.

Current law

States are required to pay back estimated misspent Federal funds, or so-called disallowances, under the AFDC quality control (QC) program. States with error rates above 3 percent are subject to repaying the Federal matching funds on the erroneous payments exceeding 3 percent. States may appeal disallowances to the Secretary of HHS, to a Departmental Appeals Board, and ultimately, to the courts.

All States but one, Nevada, are subject to disallowances. Currently, the States have been informed that they owe a total of about \$1.2 billion to the Federal government for misspent Federal funds

from fiscal years 1981 through 1986. A moratorium on collecting these disallowances expired on July 1, 1989.

House bill

(a) To resolve the backlog of pending disallowances, defined as all disallowances from fiscal years 1981 through 1990, the following statutory changes would be made:

1. For fiscal years 1983 through 1990, States would be subject to potential disallowances if their official error rates are above the lowest national annual average achieved since 1980. In the case of fiscal years 1981 and 1982, this threshold would be the higher of: (a) the lowest national annual average achieved since 1980, or (b) the target error rate in effect for fiscal years 1981 and 1982 for the respective States. The lowest national average achieved from 1981 through 1987 was 6.0 percent in 1984. Consequently, the 6.0 percent figure would apply for 1981 through 1987. If a lower national average than 6.0 percent is achieved in 1988, 1989, or 1990, it would be used to establish the threshold. Otherwise, 6.0 percent would apply to these years also.

2. State official error rates would be recalculated excluding so-called "technical errors." Technical errors are errors which, if corrected, would not result in a change in benefit amount, including failure to secure or apply for a Social Security number, failure to register for a work program, failure to assign child support rights, failure to assign rights to third party payments, and failure to obtain monthly reports from cases for which they are required.

3. All States subject to potential disallowances would have one of two options:

(a) Pay 75 percent of the potential disallowance in lieu of any further appeal; or

(b) Appeal directly to the Departmental Appeals Board. There would be no appeal to the Secretary for a waiver of the disallowance. States would have 6 months from the later of the date of enactment or the official announcement of the disallowance in which to file an appeal. The Board must rule on the appeal within 12 months from the date on which the appeal is filed. Interest would accrue on disallowances beginning after the Departmental Appeals Board decision and would be collected after appeals are exhausted. Interest is paid only on the final disallowance amount at the rate described in section 3717(a)(1) of title 31, U.S.C. A State may seek judicial review of a decision by the Board in any U.S. district court within 12 months after the decision is issued.

4. In deciding how much, if any, sanction would be imposed on the States, the Board must consider the following illustrative, but not all inclusive, list of factors:

Whether the State's error rate is sufficiently statistically reliable to support a conclusion that the State exceeded the tolerance level;

Whether the errors for which the State was cited in fact represented misspending of funds;

Whether the errors for which the State was cited could have been avoided by the State agency by cost-efficient means that would not have interfered with program purposes;

Whether the State's error rate in a year diverges from its historical trend enough to demonstrate a significant problem in need of correction;

Whether the error rate was affected by factors beyond the State's control, such as caseload growth, caseload composition, program changes, strikes, or natural disasters;

Whether the State's record with respect to corrective action demonstrates a concerted effort to reduce errors;

Whether measurement of errors was against State practice as outlined in State regulations and policy clarifications; and

Any other factors the Board determines to be relevant.

Effective date

July 1, 1989, applying to potential disallowances for fiscal years 1981 through 1990.

Senate amendment

No provision.

Conference agreement

The conference agreement permanently waives all disallowances through fiscal year 1991.

b. Permanently modify the quality control system after fiscal year 1990

Section 10281 of House bill.

Current law

States are required to pay back estimated misspent Federal funds, or so-called disallowances, under the AFDC quality control (QC) program. States with error rates above 3 percent are subject to repaying the Federal matching funds on the erroneous payments exceeding 3 percent. States may appeal disallowances to the Secretary of HHS, to a Departmental Appeals Board, and ultimately, to the courts.

House bill

(b) The following modifications would be made in the existing AFDC quality control system, beginning with fiscal year 1991:

1. Technical errors (as defined in the previous section) would be determined but excluded from all error rates for purposes of estimating disallowances. Failure to register for a work program would not be a technical error under the new system because the new JOBS program does not require registration.

2. Standard errors and 95 percent confidence intervals must be published.

3. Thresholds for State error rates would be:

Below incentives threshold: Incentives paid.

Between incentives and disallowance thresholds: Corrective actions required.

Above Disallowance Threshold: Potential disallowance imposed and corrective actions required.

The incentives threshold would be one-half of the lowest sum of the national average overpayment and underpayment error rates ever achieved in prior years beginning with fiscal year 1981. Technical errors would be excluded from the overpayment error rates.

The disallowance threshold, would be one percentage point plus the lowest sum of the national average overpayment and underpayment error rates ever achieved in prior years beginning with fiscal year 1981. Technical errors would be excluded from the overpayment error rates.

Incentive payments would equal half the difference between the incentive threshold and the State's error rate times the Federal share of the State's total payments.

Disallowances are the Federal share of erroneous payments in excess of the disallowance threshold.

4. As in the resolution of the backlog of disallowances, States would have one of two options:

(a) pay 75 percent of the potential disallowance in lieu of any further appeal; or

(b) appeal the sanction directly to the Departmental Appeals Board within 45 days. The Department of Health and Human Services waiver process would be eliminated. The Board would follow the same procedure as outlined under the backlog proposals. In addition, the Board must consider whether the State's error rate is based on errors that are reflected in other welfare programs and whether offsetting savings in other programs might have resulted from misspending on the AFDC program. A State may seek judicial review of a decision of the Board in any U.S. district court within 12 months after the decision is issued.

5. Interest would accrue on disallowances beginning after the Departmental Appeals Board decision and would be collected after appeals are exhausted. Interest would be paid on only the final disallowance amount at the rate described in section 3717(a)(1) of title 31, U.S.C.

6. Requires States to collect and report data on underpayments and negative case actions as part of the basic quality control sample. Negative case actions include improper denials and terminations. The Secretary would be required to study negative case actions and make recommendations to Congress on how to incorporate them into State error rates and the Federal incentive and disallowance formulas. States must begin reporting all data by no later than October 1, 1990. The Secretary must report to Congress no later than October 1, 1992.

Effective date

Date of enactment.

Senate amendment

No provision.

Conference agreement

The conference agreement includes a new quality control system beginning in fiscal year 1991. In general, the new system:

(1) Imposes penalties on those States whose error rates are above the national average.

(2) Establishes penalties based on a sliding scale which reflect the degree to which a State's error rates exceed the national average.

(3) Takes into account both overpayments and underpayments that are made to AFDC recipients, and gives States an incentive to improve their AFDC child support collection programs.

(4) Establishes a new Quality Control Review Panel to assure that quality control review cases that are in dispute between States and the Federal government are resolved in a uniform and fair manner. The current Secretary's waiver procedure would no longer exist.

(5) Retains the Departmental Appeals Board to resolve all other issues in dispute between the States and the Federal government.

Error measurement.—The conferees assume that the Secretary will use the same statistical methods to estimate errors as have been used under the current quality control system. Before the official error rate is determined, States may challenge the Federal review decisions by requesting reconsideration of any decisions on cases that are different from their own ("difference" cases) by a new Quality Control Review Panel to be established by the Secretary. Decisions by the Quality Control Review Panel will be on the record and will not be appealable to the Departmental Appeals Board. Decisions on difference cases may not be appealed to the court until the disallowance has become final (as a result of a decision by the Departmental Appeals Board or the decision of the State not to pursue an appeal to that Board).

In establishing a State's error rate, certain types of errors will be excluded: (1) errors based on failure to carry out properly changes in Federal legislation for a period of 6 months after the effective date of the legislation or the issuance of interim final or final regulations, whichever is later (however, States would not be relieved of the obligation to implement new legislation); (2) errors resulting from a State agency's correct use of erroneous information received from Federal agencies (e.g., the amount of a supplemental security income benefit); (3) errors resulting from a State agency's action based on written Federal policies (e.g., written advisories made in response to State inquiries); (4) errors due to circumstances (defined as those resulting in a declaration of a state of emergency by the governor or the President); and (5) errors due to monthly reporting that do not affect the amount of payment. The following errors would be counted: lack of a social security number in the file (unless an application for a number has been filed) and failure to assign child support rights.

The decision as to whether a case is in error will be made by comparison against permissible State practice (i.e., policies consistent with the approved State plan). However, if the State plan is inconsistent with Federal regulations, Federal regulations will prevail if the Secretary has informed the State of the inconsistency. If a change in State law is required, the Secretary may allow a reasonable time for the State to make the required change. A case

which is at variance with Federal law and regulations because of compliance with a court order will be reviewed against the court order.

The Secretary, in consultation with the States, will establish regulations setting forth the time period in which reviews must be completed and findings must be reported; the time period in which difference cases must be resolved; the time period in which error rates must be issued; and the sample size necessary to obtain a statistically valid error rate. To enable the Department of HHS to meet these regulatory timetables, the Secretary must insure that there will be adequate staff to perform required functions, and shall report annually to the Senate Committee on Finance and the House Committee on Ways and Means as to whether the timetables have been met. If a State fails to complete its reviews on a timely basis, the Secretary may conduct the reviews on his own initiative and will charge the State for any costs incurred in making the reviews.

Determination of disallowances.—In general, the Federal government will provide matching funds for all approvable State expenditures except for those in excess of the error tolerance level. The error tolerance level will be the national average error rate or four percent, whichever is higher, computed by determining the overpayment error rate for each State and determining the average for all States.

Disallowances for States with error rates above the error tolerance level will be assessed on a sliding scale, reflecting the degree to which the State's error rate exceeds the error tolerance level. For example, a State with an error rate of 7.8 percent is 20 percent above a 6.5 percent national average tolerance level and would owe 20 percent of the sanction on the entire amount of its overpayments above the tolerance level (20 percent \times 1.3 percent \times the Federal share of benefits). In no case, however, would a State be required to repay more than 100 percent of its overpayments above the tolerance level.

Any sanction amount owed by a State will be due upon issuance by the Secretary of the notice to the State of a disallowance. The State may pay immediately, or the Secretary and the State may negotiate an agreement under which repayment may be made over a period of up to two and one-half years. Interest will accrue beginning 45 days after the date the State receives the notice of the disallowance. If a subsequent appeal is decided in the State's favor, the Federal government will repay all State payments with interest.

Before repayment to the Federal government, several adjustments shall be made.

If a State's error rate for underpayments is below the national average, its repayment amount shall be reduced as follows: if the underpayment rate is 0.1 percentage point below the national average, the error rate would be reduced by 0.1 percentage point. This reduction could be applied to any penalty due for the measurement year or for either of the following two years. The Secretary would be required to conduct a study and report to Congress on negative case actions—improper denials and terminations.

A State's repayment amount will also be reduced by a percentage equal to the percentage improvement in its AFDC child support collection rate (the number of AFDC cases for which a child support collection is made over the total number of AFDC cases) measured against the average collection rate for the State in the preceding three years, or the percentage by which the State's AFDC child support collection rate exceeds the national average, whichever is greater.

The amount to be repaid will be further reduced to reflect overpayments recovered by the State as follows: Multiply the Federal share of recovered overpayments by the ratio of the Federal share of erroneous payments above the error tolerance level to the Federal share of all erroneous payments in the State. The resulting sum shall be subtracted from the repayment amount.

Appeal procedures.—If a State decides to appeal its disallowance to the Departmental Appeals Board, it must do so within 60 days of the notice of disallowance. In deciding whether to uphold the disallowance or any portion of it, the conferees expect the Board to conduct a thorough review of the issues and to take into account all relevant evidence. With respect to difference cases, the Departmental Appeals Board will adopt the decision of the Quality Control Review Panel.

If an appeal is not completed by the Board within 90 days, interest will be suspended until the appeal is completed. A State may appeal a decision by the Departmental Appeals Board (including a decision adopted by the Board with respect to a difference case) to Federal district court within 90 days of the decision by the Board. Court review shall be on the record established in the Departmental Appeals Board review in accordance with the standard of review prescribed by section 706(2)(A) through (E) of title 5 of the U.S.C.

Effective date; treatment of disallowances for prior years.—The new quality control system will be effective beginning with fiscal year 1991. Disallowances imposed in 1992 will be based on error rates determined for 1991. All disallowances for error rates determined for years prior to 1991 will be waived permanently.

Hypothetical example of quality control computation

[Assumes: State overpayment rate: 8%, underpayment rate: 2.8%; National overpayment rate: 6%, underpayment rate: 3.0%]

1. Calculation of State error rate:	
a. National underpayment rate	3.0%
(less) State underpayment rate	2.8%
	<hr/>
Underpayment "bonus"	0.2%
	<hr/>
b. State overpayment rate	8.0%
(less) Underpayment "bonus"	0.2%
	<hr/>
"Error rate"	7.8%
	<hr/>
2. Calculation of "basic" disallowance:	
State's AFDC payments	10,000,000
(times) Federal match rate	50%
	<hr/>
Gross Federal Cost	5,000,000

(times) Excess error rate (7.8% is 1.8 percentage points above 6% national average).....	1.8%
Excess erroneous payment.....	90,000
(times) Percent by which error rate exceeds national average. (7.8% is 30% above 6%).....	30%
"Basic" disallowance.....	27,000
3. Adjustment for overpayment recoveries:	
Overpayment recoveries (Federal share).....	5,000
(times) State error rate above national average (1.8%) as a percent of total State error rate (7.8%). (1.8% is 23% of 7.8%).....	23%
Overpayment adjustment.....	1,150
4. Adjustment for child support improvement:	
a. Percent by which AFDC child support collection rate (e.g. 16%) exceeds national AFDC child support collection rate (e.g. 12%). (16% is 33% higher than 12%).....	33%
b. Percent by which AFDC child support collection rate (e.g. 16%) exceeds State average over 3 prior years (e.g. 14%). (16% is 14% higher than 14%).....	14%
c. "Basic" disallowance from step 2.....	27,000
(less) Overpayment adjustment (step 3).....	1,150
Adjusted disallowance.....	25,850
(times) Child support adjustment percent (higher of 4.a. or 4.b.).....	33%
Child support adjustment.....	8,530
5. Final calculation:	
Adjusted disallowance (4.c.).....	25,850
(less) Child support adjustment.....	8,530
Final disallowance amount.....	17,320

AFDC AND EMERGENCY ASSISTANCE REGULATIONS

Section 10263 of House bill.

Current law

The Stewart B. McKinney Homeless Assistance Amendments Act of 1988 prohibits the Secretary of Health and Human Services, prior to September 30, 1989, from taking any action that would have the effect of implementing, in whole or in part, the proposed regulations published in the Federal Register on December 14, 1987. These regulations would have restricted the use of AFDC emergency assistance funds for homeless families and would have limited States' authority to use AFDC funds for shelter in temporary quarters, whether as a basic or special need.

The Department of Health and Human Services was required to report, by July 1, 1989, with recommendations for statutory and regulatory changes designed to: (1) improve the ability of the AFDC program to respond to emergency needs of AFDC eligible families; and (2) eliminate the use of AFDC funds for shelter costs in so-called "welfare hotels." This report was sent to Congress July 3, 1989.

House bill

Extends for one year, through September 30, 1990, the moratorium barring the Secretary of Health and Human Services from

taking any action that would have the effect of implementing, in whole or in part, the proposed regulations published in the Federal Register on December 14, 1987.

Effective date

October 1, 1989.

Senate amendment

No provision.

Conference agreement

The conference agreement directs the Secretary of HHS not to implement the proposed regulation published December 14, 1987 with respect to the use of emergency assistance or special needs funds, but permits the Secretary to issue revised proposed regulations with respect to the use of emergency assistance funds that reflect the recommendations included in a report entitled "Use of the Emergency Assistance and AFDC Programs to Provide Shelter to Families" transmitted by the Secretary to the Congress on July 3, 1989. The Secretary would be prohibited from establishing an effective date for any final regulations relating to emergency assistance, or otherwise modifying current policy regarding the use of emergency assistance or special needs funds, without specific legislative authority, prior to October 1, 1990.

Effective with the calendar quarter beginning January 1, 1990, States would be required to identify in their financial reports any emergency assistance or AFDC special needs funds that are used to pay for housing in welfare hotels or similar housing arrangements. The conferees expect that the Secretary will require the States to report information according to the type of temporary housing (as classified by the Secretary, but to include welfare hotels, other temporary commercial facilities, and other similar temporary living arrangements), and separately for the AFDC and emergency assistance programs.

Effective date

On enactment.

3. MINNESOTA FAMILY INVESTMENT PLAN (MFIP) DEMONSTRATION
PROJECT

Section 10265 of House bill.

Current law

The State of Minnesota has passed legislation to conduct field trials of the Minnesota Family Investment Plan (MFIP) as an alternative to the present Aid to Families with Dependent Children (AFDC) program. The legislation authorizes the Minnesota Commissioner of Human Services to enter into an agreement with the Federal government consistent with the goals of the MFIP. The field trials cannot proceed without Federal authorizing legislation.

House bill

Permit the State of Minnesota to conduct a demonstration project, through two field trials involving up to 6,000 families at any one time, of its proposed MFIP, subject to the approval of the Secretary. One field trial would consist of a rural county(ies), the other of an urban county(ies). The demonstration would simplify the welfare system and increase recipient work incentives.

Except where otherwise provided, the requirements of the State plan approved under Title IV-A would apply to the project, unless waived by the Secretary. The Secretary could waive any requirement of part A or F of title IV that would prevent the State from carrying out the project or achieving its purposes, but only to the extent necessary to enable the State to carry out the project.

The Secretary could not: (1) waive any requirement of sec. 402(a)(4) or 482(h) of the Social Security Act (relating to fair hearing requirements and dispute resolution procedures); (2) permit the State to provide cash assistance to any family in an amount less than the aggregate value of the AFDC and food stamp assistance the family would have received had the demonstration not been in effect; or (3) waive any requirement of section 402(a)(19)(C) of the Social Security act (relating to exemptions from participation in JOBS activities).

The State is authorized to require the participation of an individual with a child age 1 or older in JOBS activities, unless the individual is otherwise exempt from participation.

At least the education, employment and training services available under the State's Title IV-F plan would be available to families required to have a contract under the project.

The demonstration would begin during the first month of a calendar quarter, and would end five years after the first day of the month during which the project begins. The demonstration could be terminated on six months' notice by the State, or, upon a finding that the State has materially failed to comply with this section and after 30 days written notice and the opportunity for a hearing, by the Secretary.

The Secretary must pay the State the amounts that would have been payable during the calendar quarter, in the absence of the demonstration project, for cash assistance, child care, education, employment and training, and administrative expenses under the State plan approved under section 402(a), and must reimburse the State at the rate of 50 percent for expenses of evaluating the effects of the project.

Cases participating in the project during a fiscal year would be excluded from any sample taken for purposes of determining the AFDC quality control error rate. However, payments made by the State under the project would be included in the calculation of any disallowance for excessive error rates.

An evaluation plan would be developed and implemented by the State, and must include treatment and control groups assigned at random in the urban field trial. The State would issue an interim and final report of the evaluation.

Effective date

Upon enactment.

Senate amendment

No provision.

Conference agreement

The conference agreement generally follows the House bill, except that it provides that the approval of the project by the Secretary of Health and Human Services is to be based on whether the application by the State meets the criteria established by this provision.

4. FAMILY SUPPORT ACT

Section 10266 of House bill.

Current law

No provision.

House bill

The Office of Legislative Counsel has identified several technical errors (i.e., incorrect cross references and citations as well as text that was inadvertently dropped) in the Family Support Act of 1988. Legislation to correct these technical errors is included.

Senate amendment

No provision.

Conference agreement

Senate recedes.

5. EXCLUSION OF AGENT ORANGE SETTLEMENTS IN DETERMINING ELIGIBILITY FOR NEEDS-TESTED PROGRAMS

Present law

Under SSI and other needs-tested programs, all forms of income generally count against eligibility for benefits unless there is a statutory provision under which the income can be disregarded. Individuals who are awarded benefits under the Agent Orange litigation could, therefore, find that the Agent Orange awards result in their losing eligibility under SSI or other programs.

House bill

No provision.

Senate amendment

No provision.

Conference agreement

The conference agreement excludes Agent Orange settlement payments from income and resources under SSI, AFDC, Medicaid, the Title XX social services block grant and several other programs. The provision would take effect on January 1, 1989.

Conference agreement

The Conference agreement does not include the Senate provision on Coast Guard fees.

AIRPORT SLOT FEES*Senate bill*

Section 304 of the Senate amendment directs the Secretary of Transportation to establish a schedule of airport slot fees to be collected and deposited in the general fund.

House bill

The House bill contains no comparable provision.

Conference agreement

The conference agreement does not include the Senate provision on slot fees.

INTERNATIONAL DEPARTURE FEES*Senate bill*

Section 302(a) of the Senate amendment directs the Secretary of Transportation to establish, assess and collect a fee for each passenger on commercial aircraft departing the United States.

House bill

The House bill contains no comparable provision.

Conference agreement

The Senate recedes to the House.

ONONDAGA LAKE RESTORATION PROGRAM*Senate bill*

Section 4301 of the Senate amendment directs the Army Corps of Engineers to carry out an environmental restoration reconnaissance study of Lake Onondaga located near Syracuse, New York.

House bill

The House bill contains no comparable provision.

Conference agreement

The Senate recedes to the House.

SECTION 11002. RESTORATION OF FUNDS SEQUESTERED

Section 11002 provides for additional budget savings by retroactively replacing the President's October 16 sequester order with a new order. The new order exactly follows all the procedures, rules, definitions, calculations, and other requirements of the Balanced Budget and Emergency Deficit Reduction Act of 1985 (as amended) with one major and three minor exceptions.

The major exception is that, instead of the \$16.1 billion in outlay reductions that were stated in the October 16 order, the new order

shall be based on a required outlay reduction only 35.6 percent as large. The new order will be in effect for the entire fiscal year, but at a lower rate of reductions. Since the new order saves a smaller amount, the old order is rescinded and any amounts (beyond those needed to be saved under the new order) are restored. If, under the old order, individual payments or contracts were reduced, rebates will be made or contracts will be adjusted to reflect the smaller savings required by the new order.

The conferees are aware that, because of the application of the "crediting" rule in section 252(f) of the Balanced Budget Act, the stated \$16.1 billion in savings in the President's October 16 order would actually have achieved \$12.3 billion, according to CBO. Since that section also applies to this new order with regard to appropriation bills enacted after October 16, 1989, the new order will also achieve actual savings smaller than the apparent \$5.75 billion—an estimated \$4.55 billion.

One minor exception applies to the Guaranteed Student Loan program. The Balanced Budget Act does not contain a mechanism to achieve different savings in that program when the size of the sequester is altered. Therefore, section 11002 provides that the GSL savings will be achieved by the full Balanced Budget Act savings in effect in the first three months of the year, with no reductions under the new order for the remainder of the year. According to CBO, those three months will achieve more than 35.6 percent of the total amount of savings that would be achieved by a full-year sequester. The savings achieved during those three months will count as savings under the new order.

A second minor exception applies to Vocation Rehabilitation Basic State Grants and the Special Milk programs. The entitlement formulas in those programs are indexed to price increases; in the event of a sequester, the COLAs are frozen. Section 11002 overrides the COLA freeze that would otherwise be in place for the full year, and instead reduces the COLA by 35.6 percent. As with GSL's, the savings achieved by partial COLAs will count as savings under the new order.

Except as noted above, all the provisions of the Balanced Budget Act apply to the calculation and implementation of the new order. Specifically, it is still required that reductions in each program, project, or activity within a budget account be proportional to the reduction in the full account. However, since the new order is not technically the order of October 16, 1989, various requirements or procedures that are ancillary to that order do not apply. Specifically, the special Congressional procedures under section 258 of the Balanced Budget Act are not available, and the administration is not required to file a new accompanying message under section 252(a)(4) of the Act.

The final minor exception to the overlap between section 11002 and provisions in Title VI that achieve reconciliation savings by continuing the Medicare sequester under the original order of October 16 in full force for part of the year (e.g. through March 31, 1990, in the case of Part B Medicare). In order to prevent the Medicare sequester that would occur under this new order from applying on top of the Title VI sequester during the period when the two are concurrent, subsection (d) provides that during that period the

Medicare cuts under Title XI will not take place. In effect, the continued Medicare cuts under Title VI (at a rate higher than the rate under Title XI) are deemed to achieve the Title XI Medicare savings during the period when the Title VI savings are in effect. After they expire, however, the Title XI Medicare savings will be in effect for the remainder of the year. This rule for the application of the Medicare reductions under Title XI is not taken into account in calculating the new OMB report and in the President's new order, although this rule then supercedes the President's new order with regard to Medicare cuts.

From the Committee on the Budget, for consideration of the House bill (except title XI and sections 10181 through 10191), and the Senate amendment (except title VI), and modifications committed to conference, and as exclusive conferees with respect to any proposal to report in total disagreement:

LEON E. PANETTA,
RICHARD A. GEPHARDT,
MARTY RUSSO,
MARVIN LEATH,
CHARLES E. SCHUMER,
BARBARA BOXER,
JIM SLATTERY,
BILL FRENZEL,
BILL GRADISON,
BILL GOODLING,

From the Committee on the Budget, for consideration of title XI and sections 10181 through 10191 of the House bill, and title VI of the Senate amendment, and modifications committed to conference:

LEON E. PANETTA,
RICHARD A. GEPHARDT,
MARTY RUSSO,
ED JENKINS,
FRANK GUARINI,
BILL FRENZEL,
BILL GRADISON,
WM. THOMAS,

From the Committee on Agriculture, for consideration of title I of the House bill, and title I of the Senate amendment, and modifications committed to conference:

E DE LA GARZA,
DAN GLICKMAN,
CHARLES STENHOLM,
JERRY HUCKABY,
GEORGE E. BROWN, Jr.,
GLENN ENGLISH,
GARY CONDIT,
EDWARD MADIGAN,
E. THOMAS COLEMAN,
ARLAN STANGELAND,
BILL SCHUETTE,

Finder's Aid

P.L. 101-382 (104 Stat. 629) Approved August 20, 1990
Customs and Trade Act of 1990

<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>104 Stat</u>	<u>H.Rep. 101-99</u>	<u>S.Rep. 101-252</u>	<u>H.C.Rep. 101-650</u>
General Provisions - Assistance for U.S. Citizens Returning from Foreign Countries	1113(d)	140	654	--	--	125

Public Law 101-382
101st Congress

An Act

To make miscellaneous and technical changes to various trade laws.

Aug. 20, 1990
[H.R. 1594]

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE AND TABLE OF CONTENTS.

(a) **SHORT TITLE.**—This Act may be cited as the “Customs and Trade Act of 1990”

(b) **TABLE OF CONTENTS.**—

Sec. 1. Short title and table of contents.

Customs and
Trade Act of
1990.
Exports.
Imports.
19 USC 2101
note.

TITLE I—TRADE AGENCY AUTHORIZATIONS, CUSTOMS USER FEES, AND
OTHER PROVISIONS

Subtitle A—Trade Agency Authorizations for Fiscal Years 1991 and 1992

- Sec. 101. United States International Trade Commission.
- Sec. 102. United States Customs Service.
- Sec. 103. Office of the United States Trade Representative.

Subtitle B—Customs User Fees

- Sec. 111. Customs user fees.
- Sec. 112. Exemption of Israeli products from certain user fees.
- Sec. 113. Customs Service administration.
- Sec. 114. GAO report on entries by mail.
- Sec. 115. Effective date.

Subtitle C—Miscellaneous Customs Provisions

- Sec. 121. Customs forfeiture fund.
- Sec. 122. Increase in value subject to administrative forfeiture; processing of money seized under the customs laws.
- Sec. 123. Annual national trade and customs law violation estimates and enforcement strategy.
- Sec. 124. Reports regarding expansion of customs preclearance operations and recovery for damage resulting from customs examinations.

Subtitle D—Miscellaneous Provisions

- Sec. 131. Treatment of Czechoslovakia and East Germany under the Generalized System of Preferences.
- Sec. 132. Technical amendments regarding nondiscriminatory trade treatment.
- Sec. 133. Competitiveness Policy Council.
- Sec. 134. Technical amendments relating to the United States-Canada Free-Trade Agreement.
- Sec. 135. Treatment of certain information under administrative protective orders.
- Sec. 136. Extension of time for preparation of report on supplemental wage allowance demonstration projects under the Worker Adjustment Assistance Program.
- Sec. 137. Drug paraphernalia.
- Sec. 138. Economic sanctions against products of Burma.
- Sec. 139. Miscellaneous technical and clerical amendments.
- Sec. 140. Increase in expenditures to provide assistance for United States citizens returning from foreign countries.
- Sec. 141. Administrative provision.
- Sec. 142. Nondiscriminatory treatment for the products of East Germany.

(1) by striking out “paragraph (3)(B)” and inserting “paragraph (3)(C)”; and

(2) by striking out “1103(f)” and inserting “1103(e)”.

(c) COBRA of 1985.—Section 13031(b)(8)(D) of the Consolidated Omnibus Budget Reconciliation Act of 1985 (19 U.S.C. 58c(b)(8)(D)) (as redesignated by section 111(b)(2)(A) of this Act) is amended—

(1) by striking out “subparagraph 9802.00.60 of the Tariff Schedules of the United States” in clause (iii) and inserting “subheading 9802.00.60 of the Harmonized Tariff Schedule of the United States”;

(2) by striking out “subparagraph 9802.00.80 of Schedules” in clause (iv) and inserting “heading 9802.00.80 of such Schedule”; and

(3) by striking out “subparagraph 9802.00.60 or 807.00 of such Schedules” in the sentence following clause (iv) and inserting “subheading 9802.00.60 or heading 9802.00.80 of such Schedule”.

SEC. 140. INCREASE IN EXPENDITURES TO PROVIDE ASSISTANCE FOR UNITED STATES CITIZENS RETURNING FROM FOREIGN COUNTRIES.

Section 1113(d) of the Social Security Act (42 U.S.C. 1313(d)) is amended to read as follows:

“(d) The total amount of temporary assistance provided under this section shall not exceed \$1,000,000 during any fiscal year beginning on or after October 1, 1989.”

13 USC 23 note.

SEC. 141. ADMINISTRATIVE PROVISION.

(a) GENERAL RULE.—The determination of whether temporary 1990 census services constitute “Federal service” for purposes of subchapter I of chapter 85 of title 5, United States Code, shall be made under the provisions of such subchapter without regard to any provision of law not contained in such subchapter.

(b) TEMPORARY 1990 CENSUS SERVICES.—For purposes of subsection (a), the term “temporary 1990 census services” means services performed by individuals appointed to temporary positions within the Bureau of the Census for purposes relating to the 1990 decennial census of population (as determined under regulations determined by the Secretary of Commerce).

SEC. 142. NONDISCRIMINATORY TREATMENT FOR THE PRODUCTS OF EAST GERMANY.

Notwithstanding any other provision of law, the President may, by proclamation, lower the rate of duty under the Harmonized Tariff Schedule of the United States on products of the German Democratic Republic that are entered, or withdrawn from warehouse for consumption, in the customs territory of the United States—

(1) after September 30, 1990; and

(2) before the beginning date on which a unified Germany is treated as a country eligible for column 1 duty treatment under such Harmonized Schedule;

to any rate of duty that is not lower than the rate that would be imposed if the column 1 general rate of duty provided for in such Schedule applied to the product at the time of entry or withdrawal.

conduct a study of the export from the United States, during the 2-year period beginning on January 1, 1991, of unprocessed hardwood timber harvested from Federal lands or public lands east of the 100th meridian. In order to carry out the provisions of this section—

(1) the Secretary of Commerce shall require each person exporting such timber from the United States to declare, in addition to the information normally required in the Shipper's Export Declarations, the State in which the timber was grown and harvested; and

(2) the Secretary of Agriculture and the Secretary of the Interior shall ensure that all hardwood saw timber harvested from Federal lands east of the 100th meridian is marked in such a manner as to make it readily identifiable at all times before its manufacture, and shall take such steps as each Secretary considers appropriate to ensure that such markings are not altered or destroyed before manufacturing.

(b) **REPORT TO CONGRESS.**—Not later than April 1, 1993, the Secretary of Commerce shall submit to the Committees on Agriculture, Interior and Insular Affairs, and Foreign Affairs of the House of Representatives and the Committee on Banking, Housing, and Urban Affairs of the Senate a report describing the volume and value of unprocessed timber grown and harvested from Federal lands or public lands east of the 100th meridian that is exported from the United States during the 2-year period beginning on January 1, 1991, the country to which such timber is exported, and the State in which such timber was grown and harvested.

16 USC 620j.

SEC. 499. AUTHORITY OF EXPORT ADMINISTRATION ACT OF 1979.

Nothing in this title shall be construed to—

(1) prejudice the outcome of pending or prospective petitions filed under, or

(2) warrant the exercise of the authority contained in, section 7 of the Export Administration Act of 1979 with respect to the export of unprocessed timber.

Approved August 20, 1990.

LEGISLATIVE HISTORY—H.R. 1594:

HOUSE REPORTS: No. 101-99 (Comm. on Ways and Means) and No. 101-650 (Comm. of Conference).

SENATE REPORTS: No. 101-252 (Comm. on Finance).

CONGRESSIONAL RECORD:

Vol. 135 (1989): June 27, considered and rejected in House.
Sept. 7, considered and passed House.

Vol. 136 (1990): Apr. 19, 20, 23, 24, considered and passed Senate, amended.
May 9, House concurred in Senate amendment with an amendment.

July 31, Senate agreed to conference report.

Aug. 3, House agreed to conference report.

WEEKLY COMPILATION OF PRESIDENTIAL DOCUMENTS, Vol. 26 (1990):

Aug. 20, Presidential statement.

CUSTOMS AND TRADE ACT OF 1990

JULY 30, 1990.—Ordered to be printed

Mr. ROSTENKOWSKI, from the committee of conference,
submitted the following

CONFERENCE REPORT

[To accompany H.R. 1594]

The committee of conference on the disagreeing votes of the two Houses on the amendment of the House to the amendment of the Senate to the text of the bill (H.R. 1594) to make miscellaneous and technical changes to various trade laws, having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows:

That the Senate recede from its disagreement to the amendment of the House to the amendment of the Senate to the text of the bill and agree to the same with an amendment as follows:

In lieu of the matter proposed to be inserted by the House amendment to the Senate amendment to the text of the bill insert the following:

SECTION 1. SHORT TITLE AND TABLE OF CONTENTS

(a) *SHORT TITLE.*—*This Act may be cited as the “Customs and Trade Act of 1990”.*

(b) *TABLE OF CONTENTS.*—

Sec. 1. Short title and table of contents.

TITLE I—TRADE AGENCY AUTHORIZATIONS, CUSTOMS USER FEES, AND OTHER PROVISIONS

Subtitle A—Trade Agency Authorizations for Fiscal Years 1991 and 1992

Sec. 101. United States International Trade Commission.

Sec. 102. United States Customs Service.

Sec. 103. Office of the United States Trade Representative.

Subtitle B—Customs User Fees

Sec. 111. Customs user fees.

Sec. 112. Exemption of Israeli products from certain user fees.

Sec. 113. Customs Service administration.

Sec. 114. GAO report on entries by mail.

Sec. 115. Effective date.

been released. It is the intention of the conferees that those prisoners to be released include Aung San Suu Kyi and Tin Oo.

If the President has not certified that Burma has met the conditions described above and the President does not impose sanctions, he must report to Congress the reasons for his decision and outline the actions he plans to take to achieve the above conditions. Such a report shall be submitted to Congress every six months for a two-year period following the enactment of this Act, or until the President imposes sanctions or makes the above-mentioned certification during that two-year period.

Miscellaneous technical and clerical amendments (section 139 of conference agreement)

The conference agreement makes strictly technical corrections in the Tariff Act of 1930 and the Consolidated Omnibus Budget Reconciliation Act of 1985 to change references to expired provisions in the Tariff Schedules of the United States to the current provisions of the Harmonized Tariff Schedule, and corrects clerical errors in paragraph and subparagraph cross-references in section 1102 of the Omnibus Trade and Competitiveness Act of 1988.

Increase in expenditures to provide assistance for United States citizens returning from foreign countries (section 140 of conference agreement)

Section 113 of the Social Security Act permits the Secretary of Health and Human Services to offer temporary assistance to American citizens who are repatriated for emergency reasons to the United States from a foreign country. Such aid may be provided because of illness, destitution, or because of external factors such as war or threat of war. The conference agreement increases the limit on expenditures under this repatriation program from \$300,000 to \$1 million annually.

Administrative provision (section 141 of conference agreement)

The conference agreement includes a provision stating that services performed after April 20, 1990, by temporary employees of the Bureau of the Census for purposes relating to the 1990 decennial census constitute "Federal service" under the unemployment compensation program. As a result, wages earned by these temporary census workers will be credited to them in determining their eligibility for unemployment compensation. This provision reverses a provision enacted into law by the Dire Emergency Supplemental Appropriations Act of 1990.

Nondiscriminatory treatment for the products of East Germany (section 142 of conference agreement)

The conference agreement includes a provision authorizing the President to proclaim lower rates of duty applicable under the Harmonized Tariff Schedule on products of East Germany at any time after September 30, 1990, and until the date on which a unified Germany is eligible for MFN column 1 rates of duty under the Harmonized Tariff Schedule of the United States. The proclaimed

Finder's Aid
P.L. 101-403 (104 Stat. 867) Approved October 1, 1990
"Continuing Appropriations for FY 1991"

<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>104 Stat.</u>	<u>H.Rep. 101-754</u>
Medicare-Payment to Hospitals for Inpatient Services--Extension of Regional Floor on Standardized Amounts	1886(d)(1)(A) (iii)	115(b)(1)	870	10

Public Law 101-403
101st Congress

Joint Resolution

Making continuing appropriations for the fiscal year 1991, supplemental appropriations for "Operation Desert Shield" for the fiscal year 1990, and for other purposes.

Oct. 1, 1990

[H.J. Res. 655]

Resolved by the Senate and House of Representatives of the United States of America in Congress assembled, That the following sums are hereby appropriated, out of any money in the Treasury not otherwise appropriated, and out of applicable corporate or other revenues, receipts, and funds, for the several departments, agencies, corporations, and other organizational units of Government for the fiscal year 1991, and for other purposes, namely:

TITLE I—CONTINUING APPROPRIATIONS

SEC. 101. (a) Such amounts as may be necessary for continuing projects or activities (not otherwise specifically provided for in this joint resolution) which were conducted in the fiscal year 1990 and for which appropriations, funds, or other authority would be available in the following appropriations Acts:

The Departments of Commerce, Justice, and State, the Judiciary, and Related Agencies Appropriations Act, 1991;

The District of Columbia Appropriations Act, 1991;

The Energy and Water Development Appropriations Act, 1991;

The Foreign Operations, Export Financing, and Related Programs Appropriations Act, 1991, notwithstanding section 10 of Public Law 91-672 and section 15(a) of the State Department Basic Authorities Act of 1956;

The Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 1991;

The Military Construction Appropriations Act, 1991;

The Rural Development, Agriculture, and Related Agencies Appropriations Act, 1991;

The Department of Transportation and Related Agencies Appropriations Act, 1991;

The Treasury, Postal Service, and General Government Appropriations Act, 1991; and

The Departments of Veterans Affairs and Housing and Urban Development, and Independent Agencies Appropriations Act, 1991.

(b) Whenever the amount which would be made available or the authority which would be granted under an Act listed in this section as passed by the House as of October 1, 1990, is different from that which would be available or granted under such Act as passed by the Senate as of October 1, 1990, the pertinent project or activity shall be continued under the lesser amount or the more restrictive authority: *Provided*, That where an item is included in only one version of an Act as passed by both Houses as of October 1, 1990, the pertinent project or activity shall be continued under the appropria-

of apportionments set forth in section 1513 of title 31, United States Code, but nothing herein shall be construed to waive any other provision of law governing the apportionment of funds.

2 USC 902 note.

SEC. 113. (a) Any order on sequestration for fiscal year 1991 issued before, on, or after the date of enactment of this joint resolution pursuant to section 252 of the Balanced Budget and Emergency Deficit Control Act of 1985 is suspended and no action shall be taken to implement any such order.

Termination
date.

(b) Subsection (a) shall cease to be effective on the date set forth in section 108(c).

Egypt.

SEC. 114. The provisions of section 518 of the Foreign Operations, Export Financing, and Related Programs Appropriations Act, 1990, and any comparable provision contained in or incorporated by reference by a joint resolution making continuing appropriations for foreign operations, export financing, and related programs for fiscal year 1991, shall not operate to prohibit the furnishing of assistance for Egypt pursuant to any program for which funds are appropriated under such Acts: *Provided*, That the authority contained in this section to furnish assistance notwithstanding section 518 of such Act, and comparable provisions contained in a subsequent Act for fiscal year 1991, shall expire on December 31, 1990.

Termination
date.

EXTENSION OF CERTAIN MEDICARE HOSPITAL PAYMENT PROVISIONS

42 USC 1395 ww
note.

SEC. 115. (a) **EXTENSION OF AREA WAGE INDEX.**—For purposes of determining the amount of payment made to a hospital under part A of title XVIII of the Social Security Act for the operating costs of inpatient hospital services for discharges occurring on or after October 1, 1990, and on or before October 20, 1990, the Secretary of Health and Human Services, in adjusting such amount under section 1886(d)(3)(E) of such Act to reflect the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage index, shall apply the area wage index applicable to such hospital as of September 30, 1990.

(b) **EXTENSION OF REGIONAL FLOOR ON STANDARDIZED AMOUNTS.**—(1) Section 1886(d)(1)(A)(iii) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(A)(iii)) is amended by striking “September 30, 1990,” and inserting “October 20, 1990,”.

42 USC 1395 ww
note.

(2) The Secretary of Health and Human Services shall make any adjustments resulting from the amendment made by paragraph (1) in the amount of the payments made to hospitals under section 1886(d) of the Social Security Act in a fiscal year for the operating costs of inpatient hospital services in a manner that ensures that the aggregate payments under such section are not greater or less than those that would have been made in the year without such adjustments.

“(h) NOTIFICATION OF CONDITIONS.—The Secretary of Defense shall notify Congress of any condition imposed by the donor on the use of any contribution accepted by the Secretary under the authority of this section.

“(i) ANNUAL AUDIT BY GAO.—The Comptroller General of the United States shall conduct an annual audit of money and property accepted by the Secretary of Defense under this section and shall submit a copy of the results of each such audit to Congress.

“(j) ITEMS INCLUDED AS CONTRIBUTIONS.—In this section, the term ‘contribution’ includes a devise of real property or a bequest of personal property.

“(k) REGULATIONS.—The Secretary of Defense shall prescribe regulations to carry out this section.”.

(2) The table of sections at the beginning of such chapter is amended by inserting at the end the following new item:

“2608. Acceptance of contributions and services for defense programs, projects, and activities.”.

(b) CONFORMING REPEAL.—The Act entitled “An Act to authorize the acceptance of conditional gifts to further the defense effort” approved July 27, 1954 (68 Stat. 566; 50 U.S.C. 1151 et seq.), is repealed.

(c) TRANSFER OF FUNDS.—Any money in the special account provided for in section 3 of the Act referred to in subsection (b) on the date of the enactment of this Act shall be credited to the Defense Cooperation Account provided for in section 2608(b) of title 10, United States Code, as added by subsection (a).

TITLE III—SUPPLEMENTAL APPROPRIATIONS FOR EMERGENCY REFUGEE ASSISTANCE

DEPARTMENT OF STATE

UNITED STATES EMERGENCY REFUGEE AND MIGRATION ASSISTANCE FUND

For an additional amount for the “United States Emergency Refugee and Migration Assistance Fund”, \$10,000,000 to remain available until expended.

Approved October 1, 1990.

LEGISLATIVE HISTORY—H.J. Res. 655:

HOUSE REPORTS: No. 101-754 (Comm. on Appropriations).
CONGRESSIONAL RECORD, Vol. 136 (1990):

Sept. 30, considered and passed House and Senate.

WEEKLY COMPILATION OF PRESIDENTIAL DOCUMENTS, Vol. 26 (1990):
Oct. 1, Presidential remarks.

CONTINUING RESOLUTION, 1991

SEPTEMBER 25, 1990.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. WHITTEN, by direction of the Committee on Appropriations,
submitted the following

REPORT

together with

ADDITIONAL VIEWS

[To accompany H.J. Res. 655]

The present situation is that the House of Representatives has passed 10 of its 13 regular fiscal year 1991 appropriations bills and the Senate has passed five. It is apparent that there is not time to complete congressional action on these bills and have them signed by the President before the beginning of the fiscal year, October 1st.

Not to enact this continuing resolution to continue the government would be disastrous in view of the current law, where sequestration will be triggered in order to meet the Gramm-Rudman deficit reduction target. An initial Presidential sequestration order was issued on August 25, 1990. It requires the withholding of funds beginning October 1st.

The effect of that order calling for sequestration would reduce current operations, programs, and projects by an estimated 30 percent, and would be disastrous not only to the Nation's economy, but would cause a breakdown of government—air safety, meat inspection, law enforcement, war on drugs, education, health, housing, veterans, research, and revenue collection. It would have a dangerous impact on a weak economy. Its effect on the Department of Defense during Operation Desert Shield could not be tolerated. For these reasons and others that are spelled out later in this report, this continuing resolution suspends sequestration.

ployee, shall be necessary if such action be due to an order issued under section 252 of the Balanced Budget and Emergency Deficit Control Act of 1985.

FOREIGN CREDIT REPORT

The Committee directs the Secretary of the Treasury to report to the Committee on Appropriations of the Senate and the Committee on Appropriations of the House of Representatives the amounts due and unpaid 365 days or more on foreign credits of the United States Government as of December 31, 1990. Such report shall identify each debtor nation and the amount of the debt, including principal and interest, and shall be provided to the Committees not later than February 20, 1991.

FOREIGN MILITARY SALES DEBT FORGIVENESS

The Committee agrees with the proposed objective of the President, but has deferred final action on the Administration's request to forgive \$6,700,000,000 in Foreign Military Sales debt for Egypt at this time. The Committee fully recognizes the significant role that Egypt is playing in the current Persian Gulf crisis, the dire economic situation it was facing prior to that crisis, and the need to respond to the problem Egypt faces. However, the Committee believes that the Administration needs additional time to make its case and to review alternative approaches before a final decision is reached.

The Committee recommends exempting Egypt from the provision of the "Brooke-Alexander Amendment", which is Section 518 of the fiscal year 1990 Foreign Operations, Export Financing and Related Programs Appropriations Act, through December 31, 1990. This waiver of the "Brooke-Alexander Amendment" will permit United States foreign assistance to continue to Egypt, regardless of their ability to make payments on their outstanding debt.

EXTENSION OF CERTAIN MEDICARE HOSPITAL PAYMENT PROVISIONS

Section 115 provides for a delay of 20 days in the effective dates of two provisions of law related to the method of payment for hospitals under the Medicare program. Under current law, payment methodology provisions related to area wage indexing and regional floor standardized amounts would be changed effective October 1, 1990. On September 25, 1990, the Chairman of the Ways and Means Committee wrote to the Appropriations Committee asking that the effective date of these provisions be delayed for three weeks in this continuing resolution in order to allow his Committee to modify the basic law through the reconciliation process. This change is necessary to avoid confusion regarding Federal payments during the period between October 1 and the date of enactment of a 1991 Reconciliation Act.

FINANCING DESERT SHIELD AND THE SAVINGS AND LOAN BAILOUT

The Nation cannot finance the military buildup in response to the situation with Iraq, estimated to cost up to \$15 billion for fiscal

Finder's Aid
P.L. 101-508 (104 Stat. 1388) Approved November 5, 1990
"Omnibus Budget Reconciliation Act of 1990"

<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>104 Stat.</u>	<u>H. Rep. 101-881</u>	<u>H.C.Rep. 101-964</u>
Federal Old-Age and Survivors Insurance Trust Fund and Federal Disability Insurance Trust Fund	201(a)	5115(a) (1) (A)	1388- 274	—	289, 941- 942
Federal Old-Age and Survivors Insurance Trust Fund and Federal Disability Insurance Trust Fund	201(a)	5115(a) (1) (B)	1388- 274	—	289, 941- 942
Federal Old-Age and Survivors Insurance Trust Fund and Federal Disability Insurance Trust Fund	201(a)	5115(a) (2)	1388- 274	—	289, 941- 942
Federal Old-Age and Survivors Insurance Trust Fund and Federal Disability Insurance Trust Fund	201(c)	13304	1388- 627	—	1160- 1161
Federal Old-Age and Survivors Insurance Trust Fund and Federal Disability Insurance Trust Fund	201(j)	5106(c)	1388- 268	—	283- 284, 933- 934
Old-Age and Survivors Insurance - Widow's Insurance Benefits (technical amendment)	202(e) (5) Redesignated as 202(e) (5) (A)	5103(c) (2) (A) (iii)	1388- 252	—	266, 926- 927
Old-Age and Survivors Insurance - Widow's Insurance Benefits (technical amendment)	202(e) (5) (A) Redesignated as 202(e) (5) (A) (i)	5103(c) (2) (A) (ii)	1388- 252	—	266, 926- 927
Old-Age and Survivors Insurance - Widow's Insurance Benefits (technical amendment)	202(e) (5) (B) Redesignated as 202(e) (5) (A) (ii)	5103(c) (2) (A) (ii)	1388- 252	—	266, 926- 927
Old-Age and Survivors Insurance - Widow's Insurance Benefits (technical amendment)	202(e) (5) (B) (i) Redesignated as 202(e) (5) (A) (i) (I)	5103(c) (2) (A) (i)	1388- 252	—	266, 926- 927

P.L. 101-508

Subject	S.S. Act Section	P.L. Section	104 Stat.	H. Rep. 101-881	H.C.Rep. 101-964
Old-Age and Survivors Insurance - Widow's Insurance Benefits (technical amendment)	202(e) (5) (B) (ii) Redesignated as 202(e) (5) (A) (i) (II)	5103(c) (2) (A) (i)	1388- 252	—	266, 926- 927
Old-Age and Survivors Insurance - Widow's Insurance Benefits	202(e) (5) (B) New	5103(c) (2) (A) (iv)	1388- 252	—	266, 926- 927
Old-Age and Survivors Insurance - Widow's Insurance Benefits	202(e) (9) New	5103(d) (1)	1388- 253	—	267, 926- 927
Old-Age and Survivors Insurance - Widower's Insurance Benefits (technical amendment)	202(f) (6) Redesignated as 202(f) (6) (A)	5103(c) (2) (B) (iii)	1388- 252	—	267, 926- 927
Old-Age and Survivors Insurance - Widower's Insurance Benefits (technical amendment)	202(f) (6) (A) Redesignated as 202(f) (6) (A) (i)	5103(c) (2) (B) (ii)	1388- 252	—	267, 926- 927
Old-Age and Survivors Insurance - Widower's Insurance Benefits (technical amendment)	202(f) (6) (B) Redesignated as 202(f) (6) (A) (ii)	5103(c) (2) (B) (ii)	1388- 252	—	267, 926- 927
Old-Age and Survivors Insurance - Widower's Insurance Benefits (technical amendment)	202(f) (6) (B) (i) Redesignated as 202(f) (6) (A) (i) (I)	5103(c) (2) (B) (i)	1388- 252	—	267, 926- 927
Old-Age and Survivors Insurance - Widower's Insurance Benefits (technical amendment)	202(f) (6) (B) (ii) Redesignated as 202(f) (6) (A) (i) (II)	5103(c) (2) (B) (i)	1388- 252	—	267, 926- 927
Old-Age and Survivors Insurance - Widower's Insurance Benefits	202(f) (6) (B) New	5103(c) (2) (B) (iv)	1388- 252	—	267, 926- 927
Old-Age and Survivors Insurance - Widower's Insurance Benefits	202(f) (9)	5103(d) (2)	1388- 252	—	268, 926- 927

P.L. 101-508

Subject	S.S. Act Section	P.L. Section	104 Stat.	H. Rep. 101-881	H.C.Rep. 101-964
Old-Age and Survivors Insurance - Application for Monthly Insurance Benefits	202(j) (4) (A)	5116(a) (1)	1388- 274	—	289, 942- 943
Old-Age and Survivors Insurance - Application for Monthly Insurance Benefits	202(j) (4) (B) (i) Stricken	5116(a) (2)	1388- 274	—	290, 942- 943
Old-Age and Survivors Insurance - Application for Monthly Insurance Benefits (technical amendment)	202(j) (4) (B) (ii) Redesignated as 202(j) (4) (B) (i)	5116(a) (2)	1388- 274	—	290, 942- 943
Old-Age and Survivors Insurance - Application for Monthly Insurance Benefits (technical amendment)	202(j) (4) (B) (iii) Redesignated as 202(j) (4) (B) (ii)	5116(a) (2)	1388- 274	—	290, 942- 943
Old-Age and Survivors Insurance - Application for Monthly Insurance Benefits	202(j) (4) (B) (iv) Stricken	5116(a) (2)	1388- 274	—	290, 942- 943
Old-Age and Survivors Insurance - Application for Monthly Insurance Benefits (technical amendment)	202(j) (4) (B) (v) Redesignated as 202(j) (4) (B) (iii)	5116(a) (2)	1388- 274	—	290, 942- 943
Reduction of Insurance Benefits - Maximum Benefits	203(a) (3) (D) New	5119(c)	1388- 279	—	295, 944- 945
Reduction of Insurance Benefits - Maximum Benefits (conforming amendment)	203(a) (6)	5119(d)	1388- 280	—	295, 944- 945
Reduction of Insurance Benefits - Maximum Benefits (conforming amendment)	203(a) (8)	5117(a) (3) (B)	1388- 277	—	292, 943
Reduction of Insurance Benefits - Deductions on Account of Work	203(b) (2)	5127(a) (1)	1388- 286	—	302, 952- 953
Reduction of Insurance Benefits - Deductions on Account of Work	203(b) (2) (B) New	5127(a) (2)	1388- 286	—	302, 952- 953

P.L. 101-508

<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>104 Stat.</u>	<u>H. Rep. 101-881</u>	<u>H.C.Rep. 101-964</u>
Reduction of Insurance Benefits - Deduction on Account of Noncovered Work Outside the U.S.	203(d) (1) (B)	5127(b) (1)	1388- 286	---	302, 952- 953
Reduction of Insurance Benefits - Deduction on Account of Noncovered Work Outside the U.S.	203(d) (1) (B) (ii) New	5127(b) (2)	1388- 286	---	302, 952- 953
Reduction of Insurance Benefits - Months to Which Earnings are Charged	203(f) (5)	5123(a) (2) (A)	1388- 284	---	300, 950
Reduction of Insurance Benefits - Months to Which Earnings are Charged	203(f) (5)	5123(a) (2) (B)	1388- 284	---	300, 950
Reduction of Insurance Benefits - Months to Which Earnings are Charged	203(f) (5)	5123(a) (2) (C)	1388- 284	---	300, 950
Overpayments and Underpayments	204(a) (1) (A)	5129(a)	1388- 287	---	303, 955- 956
Evidence, Procedure, and Certification for Payment	205(b) (3)	5107(a) (1)	1388- 254	---	284, 933- 934
Evidence, Procedure, and Certification for Payment	205(j) (1)	5105(a) (1) (A)	1388- 254	---	269, 928- 933
Evidence, Procedure, and Certification for Payment	205(j) (2)	5105(a) (2) (A) (i)	1388- 255	---	270, 928- 933
Evidence, Procedure, and Certification for Payment	205(j) (3) (B) Stricken	5105(b) (1) (A) (i)	1388- 263	---	278, 928- 933
Evidence, Procedure, and Certification for Payment (technical amendment)	205(j) (3) (C) Redesignated as 205(j) (3) (B)	5105(b) (1) (A) (ii)	1388- 263	---	278, 928- 933

P.L. 101-508

Subject	S.S. Act Section	P.L. Section	104 Stat.	H. Rep. 101-881	H.C.Rep. 101-964
Evidence, Procedure, and Certification for Payment (technical amendment)	205(j) (3) (D) Redesignated as 205(j) (3) (C)	5105(b) (1) (A) (ii)	1388- 263	—	278, 928- 933
Evidence, Procedure, and Certification for Payment	205(j) (3) (D)	5105(b) (1) (A) (iii)	1388- 263	—	278, 928- 933
Evidence, Procedure, and Certification for Payment (technical amendment)	205(j) (3) (E) Redesignated as 205(j) (3) (D)	5105(b) (1) (A) (ii)	1388- 263	—	278, 928- 933
Evidence, Procedure, and Certification for Payment	205(j) (3) (E) New	5105(b) (1) (A) (iv)	1388- 263	—	278, 928- 933
Evidence, Procedure, and Certification for Payment	205(j) (3) (F) New	5105(b) (1) (A) (iv)	1388- 263	—	278, 928- 933
Evidence, Procedure, and Certification for Payment (technical amendment)	205(j) (4) Redesignated as 205(j) (5)	5105(a) (3) (A) (i)	1388- 260	—	275, 928- 933
Evidence, Procedure, and Certification for Payment	205(j) (4) New	5105(a) (3) (A) (i)	1388- 260	—	275, 928- 933
Evidence, Procedure, and Certification for Payment (technical amendment)	205(j) (5) Redesignated as 205(j) (6)	5105(c) (1)	1388- 265	—	280, 928- 933
Evidence, Procedure, and Certification for Payment	205(j) (5) New	5105(c) (1)	1388- 265	—	280, 928- 933
Evidence, Procedure, and Certification for Payment	205(j) (5)	5105(d) (1) (A)	1388- 265	—	280- 281, 928- 933
Evidence, Procedure, and Certification for Payment	205(s)	5109(a) (1)	1388- 271	—	286, 937
Representation of Claimants (technical amendment)	206(a) Redesignated as 206(a) (1)	5106(a) (1) (A)	1388- 266	—	281, 933- 934

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<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>104 Stat.</u>	<u>H. Rep. 101-881</u>	<u>H.C.Rep. 101-964</u>
Representation of Claimants	206(a)	5106(a) (1) (B)	1388- 266	—	281, 933- 934
Representation of Claimants	206(a) (1)	5106(a) (1) (C)	1388- 266	—	281, 933- 934
Penalties	208	5121(b) (4)	1388- 283	—	299, 947- 948
Penalties	208	5121(b) (5)	1388- 283	—	299, 947- 948
Penalties	208	5121(b) (6)	1388- 283	—	299, 947- 948
Penalties	208	5130(a) (1)	1388- 289	—	305, 956
Penalties (technical amendment)	208(a) Redesignated as 208(a) (1)	5121(b) (3)	1388- 283	—	299, 947- 948
Penalties (technical amendment)	208(a) (1) Redesignated as 208(a) (1) (A)	5121(b) (1)	1388- 283	—	299, 947- 948
Penalties (technical amendment)	208(a) (2) Redesignated as 208(a) (1) (B)	5121(b) (1)	1388- 283	—	299, 947- 948
Penalties (technical amendment)	208(a) (3) Redesignated as 208(a) (1) (C)	5121(b) (1)	1388- 283	—	299, 947- 948
Penalties (technical amendment)	208(b) Redesignated as 208(a) (2)	5121(b) (3)	1388- 283	—	299, 947- 948
Penalties (technical amendment)	208(c) Redesignated as 208(a) (3)	5121(b) (3)	1388- 283	—	299, 947- 948

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<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>104 Stat.</u>	<u>H. Rep. 101-881</u>	<u>H.C.Rep. 101-964</u>
Penalties (technical amendment)	208(d) Redesignated as 208(a) (4)	5121(b) (3)	1388- 283	—	299, 947- 948
Penalties	208(d) New	5121(a)	1388- 283	—	298, 947- 948
Penalties (technical amendment)	208(e) Redesignated as 208(a) (5)	5121(b) (3)	1388- 283	—	299, 947- 948
Penalties (technical amendment)	208(f) Redesignated as 208(a) (6)	5121(b) (3)	1388- 283	—	299, 947- 948
Penalties (technical amendment)	208(g) Redesignated as 208(a) (7)	5121(b) (3)	1388- 283	—	299, 947- 948
Penalties (technical amendment)	208(g) (1) Redesignated as 208(a) (7) (A)	5121(b) (2)	1388- 283	—	299, 947- 948
Penalties	208(g) (2)	5121(b) (2)	1388- 283	—	299, 947- 948
Penalties	208(g) (3)	5121(b) (2)	1388- 283	—	299, 947- 948
Penalties (technical amendment)	208(h) Redesignated as 208(a) (8)	5121(b) (3)	1388- 283	—	299, 947- 948
Definition of Wages	209(a) (7) (B)	5130(a) (5)	1388- 289	—	305, 956
Definition of Employment (technical amendment)	210(a) (7) (D)	11332(a) (1)	1388- 469	243, 357- 359	493, 1103- 1105
Definition of Employment (technical amendment)	210(a) (7) (E)	11332(a) (2)	1388- 469	243, 357- 359	493, 1103- 1105

P.L. 101-508

<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>104 Stat.</u>	<u>H. Rep. 101-881</u>	<u>H.C.Rep. 101-964</u>
Definition of Employment	210(a) (7) (F) New	11332(a) (3)	1388- 469	243, 357- 359	493- 494, 1103- 1105
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AFDC - State Plans for Aid and Services to Needy Families with Children	402(a) (14)	5051(a) (2)	1388- 227	—	241, 909- 910
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Peer Review of the Health Care Services - Functions of Peer Review Organizations (technical amendment)	1154(a) (3) (E) Redesignated as 1154(a) (3) (E) (i)	4205(g) (1) (A) (ii)	1388- 115	---	122, 806- 810
Peer Review of the Health Care Services - Functions of Peer Review Organizations	1154(a) (3) (E) (i)	4205(g) (1) (A) (ii)	1388- 114	---	122, 806- 810
Peer Review of the Health Care Services - Functions of Peer Review Organizations	1154(a) (3) (E) (i)	4205(g) (1) (A) (iii)	1388- 114	---	122, 806- 810
Peer Review of the Health Care Services - Functions of Peer Review Organizations	1154(a) (3) (E) (ii) New	4205(g) (1) (A) (iv)	1388- 114	---	122, 806- 810
Peer Review of the Health Care Services - Functions of Peer Review Organizations	1154(a) (4) (B)	4358(b) (3)	1388- 137	91- 95	145, 783- 806
Peer Review of the Health Care Services - Functions of Peer Review Organizations	1154(a) (7) (A) (i)	4205(b) (1) (A)	1388- 113	86	120, 806- 810

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Subject	S.S. Act Section	P.L. Section	104 Stat.	H. Rep. 101-881	H.C.Rep. 101-964
Peer Review of the Health Care Services - Functions of Peer Review Organizations (technical amendment)	1154(a) (9) Redesignated as 1154(a) (9) (A)	4205(d) (1) (A) (i)	1388- 113	86	121, 806- 810
Peer Review of the Health Care Services - Functions of Peer Review Organizations	1154(a) (9) (B) New	4205(d) (1) (A) (ii)	1388- 113	86	121, 806- 810
Peer Review of the Health Care Services - Functions of Peer Review Organizations	1154(a) (16)	4027(a) (1) (B)	1388- 117	--	125, 810- 819
Peer Review of the Health Care Services - Functions of Peer Review Organizations	1154(c)	4205(b) (1) (B)	1388- 113	86	120, 806- 810
Peer Review of the Health Care Services - Obligations of Health Care Practitioners	1156(b) (1)	4205(a) (1) (A)	1388- 112	--	120, 806- 810
Peer Review of the Health Care Services - Obligations of Health Care Practitioners	1156(b) (1)	4205(a) (1) (B)	1388- 112	--	120, 806- 810
Peer Review of the Health Care Services - Obligations of Health Care Practitioners	1156(b) (6) New	4205(d) (2) (A)	1388- 114	86	121, 806- 810
Peer Review of the Health Care Services - Limitation on Liability	1157(b)	4205(f) (1)	1388- 114	--	122, 806- 810
Peer Review of the Health Care Services - Limitation on Liability	1157(b)	4205(f) (2)	1388- 114	--	122, 806- 810
Peer Review of the Health Care Services - Limitation on Liability	1157(b)	4205(f) (3)	1388- 114	--	122, 806- 810
Peer Review of the Health Care Services - Prohibition Against Disclosure of Information (technical amendment)	1160(b) (1) (B)	4205(d) (1) (B) (i)	1388- 113	86	121, 806- 810

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<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>104 Stat.</u>	<u>H. Rep. 101-881</u>	<u>H.C.Rep. 101-964</u>
Peer Review of the Health Care Services - Prohibition Against Disclosure of Information	1160(b) (1) (C)	4205(d) (1) (B) (ii)	1388- 113	86	121, 806- 810
Peer Review of the Health Care Services - Prohibition Against Disclosure of Information	1160(b) (1) (D) New	4205(d) (1) (B) (iii)	1388- 113	86	121, 806- 810
Peer Review of the Health Care Services - Prohibition Against Disclosure of Information	1160(d)	4205(e) (1)	1388- 114	85	121, 806- 810
Supplemental Security Income - Meaning of Income	1612(a) (1) (C)	5034(a) (1) (A)	1388- 225	—	238, 904- 905
Supplemental Security Income - Meaning of Income	1612(a) (1) (E) New	5034(a) (1) (B)	1388- 225	—	238, 904- 905
Supplemental Security Income - Meaning of Income	1612(a) (2) (F)	5034(a) (2)	1388- 225	—	238, 904- 905
Supplemental Security Income - Exclusions from Income	1612(b) (4) (B) (ii)	5033(a)	1388- 224	—	238, 904
Supplemental Security Income - Exclusions from Income (technical amendment)	1612(b) (15)	5031(a) (1)	1388- 224	—	237, 903
Supplemental Security Income - Exclusions from Income (technical amendment)	1612(b) (16)	5031(a) (2)	1388- 224	—	237, 903
Supplemental Security Income - Exclusions from Income (technical amendment)	1612(b) (16)	5035(a) (1)	1388- 225	—	238, 905

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<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>104 Stat.</u>	<u>H. Rep. 101-881</u>	<u>H.C.Rep. 101-964</u>
Supplemental Security Income - Exclusions from Income	1612(b) (17)	5031(a) (3)	1388- 224	—	237, 903
Supplemental Security Income - Exclusions from Income (technical amendment)	1612(b) (17)	5035(a) (2)	1388- 225	—	238, 905
Supplemental Security Income - Exclusions from Income (technical amendment)	1612(b) (17) *	11115(b) (1)	1388- 414	—	436, 1035- 1041
Supplemental Security Income - Exclusions from Income	1612(b) (18) New	5035(a) (3)	1388- 225	—	238, 905
Supplemental Security Income - Exclusions from Income (technical amendment)	1612(b) (18)	11115(b) (1)	1388- 414	—	436, 1035- 1041
Supplemental Security Income - Exclusions from Income	1612(b) (19) New	11115(b) (1) (C)	1388- 414	—	436, 1035- 1041
Supplemental Security Income - Exclusions from Resources (technical amendment)	1613(a) (7)	5031(b) (1)	1388- 224	—	237, 903
Supplemental Security Income - Exclusions from Resources (technical amendment)	1613(a) (8)	5031(b) (2)	1388- 224	—	237, 903
Supplemental Security Income - Exclusions from Resources (technical amendment)	1613(a) (8)	5035(b) (1)	1388- 225	—	238, 905

* Unable to execute. No "and".

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<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>104 Stat.</u>	<u>H. Rep. 101-881</u>	<u>H.C.Rep. 101-964</u>
Supplemental Security Income - Exclusions from Resources (technical amendment)	1613(a) (8) *	11115(b) (2) (A)	1388- 414	—	436, 1035- 1041
Supplemental Security Income - Exclusions from Resources	1613(a) (9) New	5031(b) (3)	1388- 224	—	237, 903
Supplemental Security Income - Exclusions from Resources (technical amendment)	1613(a) (9)	5035(b) (2)	1388- 225	—	238, 905
Supplemental Security Income - Exclusions from Resources (technical amendment)	1613(a) (9) **	11115(b) (2) (B)	1388- 414	—	436, 1035- 1041
Supplemental Security Income - Exclusions from Resources	1613(a) (10) New	5035(b) (3)	1388- 225	—	238, 905
Supplemental Security Income - Exclusions from Resources	1613(a) (10) New	11115(b) (2) (C)	1388- 414	—	436, 1035- 1041
Supplemental Security Income - Meaning of Terms - Aged, Blind or Disabled Individual	1614(a) (3) (H) (i) New	5036(a)	1388- 225	—	239, 905- 906
Supplemental Security Income - Rehabilitation Services for Blind and Disabled Individuals	1615(e) New	5037(a)	1388- 226	—	239, 906

* Unable to execute. No "and".

** Section 11115(b) (2) (B) makes the same amendment as section 5035(b) (2).

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<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>104 Stat.</u>	<u>H. Rep. 101-881</u>	<u>H.C.Rep. 101-964</u>
Supplemental Security Income - Benefits for Individuals Who Perform Substantial Gainful Activity Despite Severe Medical Impairment	1619(b) (1)	5032(a)	1388- 224	—	237, 903- 904
Supplemental Security Income - Benefits for Individuals Who Perform Substantial Gainful Activity Despite Severe Medical Impairment (technical amendment)	1619(c) Redesignated as 1619(d)	5039(a) (1)	1388- 226	—	240, 907- 908
Supplemental Security Income - Benefits for Individuals Who Perform Substantial Gainful Activity Despite Severe Medical Impairment	1619(c) New	5039(a) (2)	1388- 226	—	240, 907- 908
Supplemental Security Income - Payment of Benefits	1631(a) (2) (A)	5105(a) (1) (B) (i)	1388- 255	—	269, 928- 933
Supplemental Security Income - Payment of Benefits	1631(a) (2) (B)	5105(a) (2) (A) (ii)	1388- 258	—	276, 928- 933
Supplemental Security Income - Payment of Benefits (conforming amendment)	1631(a) (2) (C) (i)	5105(a) (1) (B) (ii) (I)	1388- 255	—	270, 928- 933
Supplemental Security Income - Payment of Benefits (conforming amendment)	1631(a) (2) (C) (ii)	5105(a) (1) (B) (ii) (II)	1388- 255	—	270, 928- 933
Supplemental Security Income - Payment of Benefits (conforming amendment)	1631(a) (2) (C) (iii)	5105(a) (1) (B) (ii) (II)	1388- 255	—	270, 928- 933
Supplemental Security Income - Payment of Benefits (conforming amendment)	1631(a) (2) (C) (iv)	5105(a) (1) (B) (ii) (II)	1388- 255	—	270, 928- 933

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<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>104 Stat.</u>	<u>H. Rep. 101-881</u>	<u>H.C.Rep. 101-964</u>
Supplemental Security Income - Payment of Benefits (conforming amendment)	1631(a) (2) (C) (v)	5105(a) (1) (B) (ii) (III) (aa)	1388- 255	—	270, 928- 933
Supplemental Security Income - Payment of Benefits (conforming amendment)	1631(a) (2) (C) (v)	5105(a) (1) (B) (ii) (III) (bb)	1388- 255	—	270, 928- 933
Supplemental Security Income - Payment of Benefits (technical amendment)	1631(a) (2) (D) Redesignated as 1631(a) (2) (E)	5105(a) (3) (A) (ii) (I)	1388- 261	—	276, 928- 933
Supplemental Security Income - Payment of Benefits	1631(a) (2) (D) New	5105(a) (3) (A) (ii) (III)	1388- 261	—	276, 928- 933
Supplemental Security Income - Payment of Benefits (technical amendment)	1631(a) (2) (E) Redesignated as 1631(a) (2) (F)	5105(c) (2)	1388- 265	—	280, 928- 933
Supplemental Security Income - Payment of Benefits	1631(a) (2) (E) New	5105(c) (2)	1388- 265	—	280, 928- 933
Supplemental Security Income - Payment of Benefits	1631(a) (2) (E)	5105(a) (1) (B)	1388- 266	—	281, 928- 933
Supplemental Security Income - Payment of Benefits	1631(a) (4) (B)	5038 (a)	1388- 226	—	239, 907
Supplemental Security Income - Payment of Benefits	1631(a) (6) (A)	5113(b) (1)	1388- 273	—	289, 940
Supplemental Security Income - Payment of Benefits	1631(a) (6) (B)	5113(b) (2)	1388- 273	—	289, 940
Supplemental Security Income - Payment of Benefits	1631(a) (9) New	5031(c)	1388- 224	—	237, 903
Supplemental Security Income - Hearings and Review (technical amendment)	1631(c) (1) Redesignated as 1631(c) (1) (A)	5107(a) (2) (A)	1388- 269	—	284, 934- 935

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<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>104 Stat.</u>	<u>H. Rep. 101-881</u>	<u>H.C.Rep. 101-964</u>
Supplemental Security Income - Hearings and Review	1631(c) (1) (B) New	5107(a) (2) (B)	1388- 269	—	284, 934- 935
Supplemental Security Income - Procedures - Prohibition of Assignments; Representation of Claimants	1631(d) (2) (A)	5106(a) (2)	1388- 269	—	283, 933- 934
Supplemental Security Income - Payment of Certain Travel Expenses	1631(h)	5106(c)	1388- 268	—	283- 284, 933- 934
Supplemental Security Income - Application and Review Requirements for Certain Individuals (conforming amendment)	1631(j) (2) (A)	5039(b)	1388- 226	—	240, 907- 908
Supplemental Security Income - Pre-Release Procedures for Institutionalized Persons	1631(m)	5040(1)	1388- 227	—	240, 908
Supplemental Security Income - Concurrent SSI and Food Stamp Applications by Institutionalized Individuals	1631(n) New	5040(2)	1388- 227	—	240, 908
Supplemental Security Income - Notice Requirements	1631(n) New	5109(d) (2)	1388- 271	—	286- 287, 937
Supplemental Security Income - Determinations of Medicaid Eligibility	1634(d)	5103(c) (1) (B)	1388- 251	—	266, 926- 927
Supplemental Security Income - Determinations of Medicaid Eligibility (technical amendment)	1634(d) (1) Redesignated as 1634(d) (1) (A)	5103(c) (1) (A)	1388- 251	—	265, 926- 927
Supplemental Security Income - Determinations of Medicaid Eligibility	1634(d) (1) (A)	5103(c) (1) (C)	1388- 251	—	266, 926- 927

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<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>104 Stat.</u>	<u>H. Rep. 101-881</u>	<u>H.C.Rep. 101-964</u>
Supplemental Security Income - Determinations of Medicaid Eligibility	1634(d) (1) (B)	5103(c) (1) (D)	1388- 251	—	266, 926- 927
Supplemental Security Income - Determinations of Medicaid Eligibility	1634(d) (1)	5103(c) (1) (E)	1388- 251	—	266, 926- 927
Supplemental Security Income - Determinations of Medicaid Eligibility (technical amendment)	1634(d) (2) Redesignated as 1634(d) (1) (B)	5103(c) (1) (A)	1388- 251	—	265, 926- 927
Supplemental Security Income - Determinations of Medicaid Eligibility	1634(d) (2) New	5103(c) (1) (E)	1388- 251	—	266, 926- 927
Medicare - Hospital Insurance Benefits - Scope of Benefits	1812(a) (4)	4006(a) (1)	1388- 43	—	46, 705
Medicare - Hospital Insurance Benefits - Scope of Benefits	1812(d) (1)	4006(a) (2) (A)	1388- 43	—	46, 705
Medicare - Hospital Insurance Benefits - Scope of Benefits	1812(d) (2) (B)	4006(a) (2) (B)	1388- 43	—	46, 705
Medicare - Hospital Insurance Benefits - Requirement of Requests and Certifications (technical amendment)	1814(a) (7) (A) (i)	4006(b) (1)	1388- 43	—	46, 705
Medicare - Hospital Insurance Benefits - Requirement of Requests and Certifications (technical amendment)	1814(a) (7) (A) (ii)	4006(b) (2)	1388- 43	—	46, 705
Medicare - Hospital Insurance Benefits - Requirement of Requests and Certifications	1814(a) (7) (A) (iii) New	4006(b) (3)	1388- 43	—	46, 705
Medicare - Hospital Insurance Benefits - Amount Paid to Providers	1814(b) (3) (B)	4008(i) (3) (A)	1388- 51	—	54, 708, 711, 714

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Subject	S.S. Act Section	P.L. Section	104 Stat.	H. Rep. 101-881	H.C.Rep. 101-964
Medicare - Hospital Insurance Benefits - Amount Paid to Providers	1814(b)	4008(i) (3) (B)	1388- 51	—	54, 708, 711, 714
Medicare - Hospital Insurance Benefits - Amount Paid to Providers	1814(b)	4008(i) (3) (C)	1388- 51	—	54- 55, 708, 711, 714
Medicare - Hospital Insurance Benefits - Payment for Hospice Care	1814(i) (1) (C) (i)	4008(m) (3) (A)	1388- 53	—	58, 711- 717
Medicare - Hospital Insurance Benefits - Use of Public Agencies or Private Organizations to Facilitate Payment to Providers of Services	1816(f)	4005(c) (1) (A) (i)	1388- 41	231- 232, 252- 254	45, 701- 704
Medicare - Hospital Insurance Benefits - Use of Public Agencies or Private Organizations to Facilitate Payment to Providers of Services (technical amendment)	1816(f) Redesignated as 1816(f) (1)	4005(c) (1) (A) (ii)	1388- 41	231- 232, 252- 254	45, 701- 704
Medicare - Hospital Insurance Benefits - Use of Public Agencies or Private Organizations to Facilitate Payment to Providers of Services	1816(f)	4005(c) (1) (A) (iii)	1388- 41	231- 232, 252- 254	45, 701- 704
Medicare - Federal Hospital Insurance Trust Fund	1817(i)	5106(c)	1388- 268	—	283- 284, 933- 934
Medicare - Hospital Insurance Benefits for Uninsured Elderly Individuals Not Otherwise Eligible (technical amendment)	1818(c) (5)	4008(g) (1) (A)	1388- 45	—	49, 715- 716

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<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>104 Stat.</u>	<u>H. Rep. 101-881</u>	<u>H.C.Rep. 101-964</u>
Medicare - Hospital Insurance Benefits for Uninsured Elderly Individuals Not Otherwise Eligible (technical amendment)	1818(c) (6)	4008(g) (1) (B)	1388- 45	—	49, 715- 716
Medicare - Hospital Insurance Benefits for Uninsured Elderly Individuals Not Otherwise Eligible	1818(c) (7) New	4008(g) (1) (C)	1388- 45	—	49, 715- 716
Medicare - Hospital Insurance Benefits for Uninsured Elderly Individuals Not Otherwise Eligible	1818(c) (8) New	4008(g) (1) (C)	1388- 45	—	49, 715- 716
Medicare - Hospital Insurance Benefits for Uninsured Elderly Individuals Not Otherwise Eligible	1818(c) (9) New	4008(g) (1) (C)	1388- 45	—	49, 715- 716
Medicare - Hospital Insurance Benefits for Uninsured Elderly Individuals Not Otherwise Eligible	1818(g) (2) (B)	4008(m) (3) (D)	1388- 54	—	58, 711- 717
Medicare - Hospital Insurance Benefits for Disabled Individuals Who Have Exhausted Other Entitlement	1818A(d) (1) (A)	4008(m) (3) (C) (i)	1388- 54	—	58, 711- 717
Medicare - Hospital Insurance Benefits for Disabled Individuals Who Have Exhausted Other Entitlement	1818(d) (1) (C) Stricken	4008(m) (3) (C) (ii)	1388- 54	—	52, 711- 717
Medicare - Hospital Insurance Benefits - Requirements for Skilled Nursing Facilities	1819(b) (1) (B)	4008(h) (2) (B)	1388- 48	—	52, 706- 714
Medicare - Hospital Insurance Benefits - Requirements for Skilled Nursing Facilities	1819(b) (3) (C) (i) (I)	4008(h) (2) (C)	1388- 48	—	52, 706- 714

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Subject	S.S. Act Section	P.L. Section	104 Stat.	H. Rep. 101-881	H.C.Rep. 101-964
Medicare - Hospital Insurance Benefits - Requirements for Skilled Nursing Facilities (technical amendment)	1819(b) (4) (A) (v)	4008(h) (2) (D) (i)	1388- 48	—	52, 54, 706- 714
Medicare - Hospital Insurance Benefits - Requirements for Skilled Nursing Facilities (technical amendment)	1819(b) (4) (A) (vi)	4008(h) (2) (D) (ii)	1388- 48	—	52, 706- 714
Medicare - Hospital Insurance Benefits - Requirements for Skilled Nursing Facilities	1819(b) (4) (A) (vii) New	4008(h) (2) (D) (iii)	1388- 48	—	52, 706- 714
Medicare - Hospital Insurance Benefits - Requirements for Skilled Nursing Facilities (technical amendment)	1819(b) (4) (C) (ii) (II)	4008(h) (2) (E) (i)	1388- 49	—	52, 706- 714
Medicare - Hospital Insurance Benefits - Requirements for Skilled Nursing Facilities (technical amendment)	1819(b) (4) (C) (ii) (III)	4008(h) (2) (E) (ii)	1388- 49	—	52, 706- 714
Medicare - Hospital Insurance Benefits - Requirements for Skilled Nursing Facilities	1819(b) (4) (C) (ii) (IV) New	4008(h) (2) (E) (iii)	1388- 49	—	52, 706- 714
Medicare - Hospital Insurance Benefits - Requirements for Skilled Nursing Facilities	1819(b) (4) (C) (ii) (V) New	4008(h) (2) (E) (iii)	1388- 49	—	52, 706- 714
Medicare - Hospital Insurance Benefits - Requirements for Skilled Nursing Facilities	1819(b) (5) (A)	4008(h) (1) (B) (i)	1388- 46	—	50, 706- 714
Medicare - Hospital Insurance Benefits - Requirements for Skilled Nursing Facilities	1819(b) (5) (A)	4008(h) (1) (B) (ii)	1388- 46	—	50, 706- 714
Medicare - Hospital Insurance Benefits - Requirements for Skilled Nursing Facilities (technical amendment)	1819(b) (5) (A) (i) Redesignated as 1819(b) (5) (A) (i) (I)	4008(h) (1) (B) (iii)	1388- 46	—	50, 706- 714

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<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>104 Stat.</u>	<u>H. Rep. 101-881</u>	<u>H.C.Rep. 101-964</u>
Medicare - Hospital Insurance Benefits - Requirements for Skilled Nursing Facilities (technical amendment)	1819(b) (5) (A) (ii) Redesignated as 1819(b) (5) (A) (i) (II)	4008(h) (1) (B) (iii)	1388- 46	—	50, 706- 714
Medicare - Hospital Insurance Benefits - Requirements for Skilled Nursing Facilities	1819(b) (5) (A) (ii) New	4008(h) (1) (B) (iv)	1388- 46	—	50, 706- 714
Medicare - Hospital Insurance Benefits - Requirements for Skilled Nursing Facilities	1819(b) (5) (C)	4008(h) (1) (C)	1388- 46	—	50, 706- 714
Medicare - Hospital Insurance Benefits - Requirements for Skilled Nursing Facilities	1819(b) (5) (D)	4008(h) (1) (D)	1388- 47	—	50, 706- 714
Medicare - Hospital Insurance Benefits - Requirements for Skilled Nursing Facilities	1819(b) (5) (F) (i)	4008(h) (2) (F)	1388- 49	—	53, 706- 714
Medicare - Hospital Insurance Benefits - Requirements for Skilled Nursing Facilities	1819(c) (1) (A) (iv)	4008(h) (2) (A)	1388- 49	—	53, 706- 714
Medicare - Hospital Insurance Benefits - Requirements for Skilled Nursing Facilities (technical amendment)	1819(c) (1) (A) (x) Redesignated as 1819(c) (1) (A) (xi)	4008(h) (2) (G) (i)	1388- 49	—	53, 706- 714
Medicare - Hospital Insurance Benefits - Requirements for Skilled Nursing Facilities	1819(c) (1) (A) (x) New	4008(h) (2) (G) (i)	1388- 49	—	53, 706- 714
Medicare - Hospital Insurance Benefits - Requirements for Skilled Nursing Facilities	1819(c) (1) (A)	4008(h) (2) (G) (B)	1388- 49	—	53, 706- 714
Medicare - Hospital Insurance Benefits - Requirements for Skilled Nursing Facilities	1819(c) (1) (B) (ii)	4008(h) (2) (I)	1388- 49	—	53, 706- 714
Medicare - Hospital Insurance Benefits - Requirements for Skilled Nursing Facilities	1819(c) (1) (E)	4206(d) (1)	1388- 116	—	124, 774- 778

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<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>104 Stat.</u>	<u>H. Rep. 101-881</u>	<u>H.C.Rep. 101-964</u>
Medicare - Hospital Insurance Benefits - Requirements for Skilled Nursing Facilities	1819(e) (1) (A)	4008(h) (2) (J)	1388- 49	---	53, 706- 714
Medicare - Hospital Insurance Benefits - Requirements for Skilled Nursing Facilities	1819(e) (2) (A)	4008(h) (2) (K) (i)	1388- 49	---	53, 706- 714
Medicare - Hospital Insurance Benefits - Requirements for Skilled Nursing Facilities	1819(e) (2) (C) New	4008(h) (2) (K) (ii)	1388- 49	---	53, 706- 714
Medicare - Hospital Insurance Benefits - Requirements for Skilled Nursing Facilities	1819(f) (2) (A) (ii)	4008(m) (3) (F)	1388- 54	---	50, 711- 717
Medicare - Hospital Insurance Benefits - Requirements for Skilled Nursing Facilities (technical amendment)	1819(f) (2) (A) (iv) (I)	4008(h) (1) (E) (i)	1388- 47	---	50, 706- 714
Medicare - Hospital Insurance Benefits - Requirements for Skilled Nursing Facilities	1819(f) (2) (A) (iv) (II)	4008(h) (1) (E) (ii)	1388- 47	---	50, 706- 714
Medicare - Hospital Insurance Benefits - Requirements for Skilled Nursing Facilities (technical amendment)	1819(f) (2) (A) (iv) (II)	4008(h) (1) (E) (iii)	1388- 47	---	50, 706- 714
Medicare - Hospital Insurance Benefits - Requirements for Skilled Nursing Facilities	1819(f) (2) (A) (iv) (III) New	4008(h) (1) (E) (iv)	1388- 47	---	50, 706- 714
Medicare - Hospital Insurance Benefits - Requirements for Skilled Nursing Facilities	1819(f) (2) (B)	4008(h) (1) (G)	1388- 48	---	51, 706- 714
Medicare - Hospital Insurance Benefits - Requirements for Skilled Nursing Facilities	1819(f) (2) (B) (iii) (I)	4008(h) (1) (F) (i)	1388- 47	---	51, 706- 714
Medicare - Hospital Insurance Benefits - Requirements for Skilled Nursing Facilities	1819(g) (1) (C)	4008(h) (2) (L)	1388- 50	---	53- 54, 706- 714

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<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>104 Stat.</u>	<u>H. Rep. 101-881</u>	<u>H.C.Rep. 101-964</u>
Medicare - Hospital Insurance Benefits - Requirements for Skilled Nursing Facilities	1819(g) (5) (A) (i)	4008(h) (2) (M)	1388- 50	—	54, 706- 714
Medicare - Hospital Insurance Benefits - Requirements for Skilled Nursing Facilities	1819(g) (5) (B)	4008(h) (2) (N)	1388- 50	—	54, 706- 714
Medicare - Hospital Insurance Benefits - Essential Access Community Hospital Program	1820(d) (1)	4008(m) (2) (B) (i)	1388- 53	—	57, 711- 717
Medicare - Hospital Insurance Benefits - Essential Access Community Hospital Program	1820(f) (1) (A)	4008(d) (3)	1388- 45	—	48, 706, 708, 711
Medicare - Hospital Insurance Benefits - Essential Access Community Hospital Program	1820(f) (1) (B)	4008(d) (2)	1388- 45	—	48, 706, 708, 711
Medicare - Hospital Insurance Benefits - Essential Access Community Hospital Program	1820(g) (1) (A) (ii)	4008(m) (2) (B) (ii)	1388- 53	—	57, 711- 717
Medicare - Hospital Insurance Benefits - Essential Access Community Hospital Program	1820(i) (2) (C)	4008(d) (1)	1388- 44	—	48, 706, 708, 711
Medicare - Hospital Insurance Benefits - Essential Access Community Hospital Program	1820(j)	4008(m) (2) (B) (iii)	1388- 53	—	57, 711- 717
Medicare - Supplementary Medical Insurance Benefits	1832(a) (2) (A)	4153(a) (2) (A) (i)	1388- 83	79- 82, 235- 237, 265- 269	89, 743- 749

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<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>104 Stat.</u>	<u>H. Rep. 101-881</u>	<u>H.C.Rep. 101-964</u>
Medicare - Supplementary Medical Insurance Benefits	1832(a) (2) (B)	4153(a) (2) (A) (i)	1388- 83	79- 82, 235- 237, 265- 269	89, 743- 749
Medicare - Supplementary Medical Insurance Benefits (technical amendment)	1832(a) (2) (B) (ii)	4155(b) (1) (A)	1388- 86	83	92, 752- 763
Medicare - Supplementary Medical Insurance Benefits (technical amendment)	1832(a) (2) (B) (iii)	4155(b) (1) (B)	1388- 86	83	92, 752- 763
Medicare - Supplementary Medical Insurance Benefits	1832(a) (2) (B) (iii)	4157(b)	1388- 89	—	95, 752- 762
Medicare - Supplementary Medical Insurance Benefits	1832(a) (2) (B) (iv) New	4155(b) (1) (C)	1388- 86	83	92, 752- 763
Medicare - Supplementary Medical Insurance Benefits (technical amendment)	1832(a) (2) (D) Redesignated as 1832(a) (2) (D) (i)	4161(a) (3) (A)	1388- 93	—	100, 752- 762
Medicare - Supplementary Medical Insurance Benefits (technical amendment)	1832(a) (2) (D) (i)	4161(a) (3) (A)	1388- 93	—	100, 752- 762
Medicare - Supplementary Medical Insurance Benefits	1832(a) (2) (D) (ii) New	4161(a) (3) (A)	1388- 93	—	100, 752- 762
Medicare - Supplementary Medical Insurance Benefits (technical amendment)	1832(a) (2) (G)	4153(a) (2) (A) (ii)	1388- 83	79- 82, 235- 237, 265- 269	89, 743- 749

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<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>104 Stat.</u>	<u>H. Rep. 101-881</u>	<u>H.C.Rep. 101-964</u>
Medicare - Supplementary Medical Insurance Benefits (technical amendment)	1832(a) (2) (H)	4153(a) (2) (A) (iii)	1388- 83	79- 82, 235- 237, 265- 269	89, 743- 749
Medicare - Supplementary Medical Insurance Benefits (technical amendment)	1832(a) (2) (H)	4162(b) (1) (A)	1388- 96	--	102, 752- 762
Medicare - Supplementary Medical Insurance Benefits	1832(a) (2) (I) New	4153(a) (2) (A) (iv)	1388- 83	79- 82, 235- 237, 265- 269	89, 743- 749
Medicare - Supplementary Medical Insurance Benefits (technical amendment)	1832(a) (2) (I)	4162(b) (1) (B)	1388- 96	--	102, 752- 762
Medicare - Supplementary Medical Insurance Benefits	1832(a) (2) (J) New	4162(b) (1) (C)	1388- 96	--	102, 752- 762
Medicare - Supplementary Medical Insurance Benefits	1833(a) (1) (H)	4118(f) (2) (D)	1388- 70	--	74, 752- 763
Medicare - Supplementary Medical Insurance Benefits (conforming amendment)	1833(a) (1) (J)	4104(b) (1)	1388- 59	72- 73, 232- 233, 254- 258	63, 719- 728
Medicare - Supplementary Medical Insurance Benefits (technical amendment)	1833(a) (1) (K)	4153(a) (2) (B) (i)	1388- 83	79- 82, 235- 237, 265- 269	89, 743- 749
Medicare - Supplementary Medical Insurance Benefits (technical amendment)	1833(a) (1) (K)	4155(b) (2) (A)	1388- 86	83	92, 752- 763

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<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>104 Stat.</u>	<u>H. Rep. 101-881</u>	<u>H.C.Rep. 101-964</u>
Medicare - Supplementary Medical Insurance Benefits	1833(a) (1) (L)	4153(a) (2) (B) (ii)	1388- 83	79- 82, 235- 237, 265- 269	89, 743- 749
Medicare - Supplementary Medical Insurance Benefits	1833(a) (1) (M) New	4153(a) (2) (B) (ii)	1388- 83	79- 82, 235- 237, 265- 269	89, 743- 749
Medicare - Supplementary Medical Insurance Benefits	1833(a) (1) (M) New	4155(b) (2) (B)	1388- 86	83	92- 93, 752- 763
Medicare - Supplementary Medical Insurance Benefits	1833(a) (2)	4153(a) (2) (C) (i)	1388- 83	79- 82, 235- 237, 265- 269	89, 743- 749
Medicare - Supplementary Medical Insurance Benefits	1833(a) (2) (E)	4163(d) (1)	1388- 100	—	106, 763- 765
Medicare - Supplementary Medical Insurance Benefits (technical amendment)	1833(a) (5)	4153(a) (2) (C) (ii)	1388- 83	79- 82, 235- 237, 265- 269	89, 743- 749
Medicare - Supplementary Medical Insurance Benefits (technical amendment)	1833(a) (6)	4153(a) (2) (C) (iii)	1388- 83	79- 82, 235- 237, 265- 269	89, 743- 749

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<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>104 Stat.</u>	<u>H. Rep. 101-881</u>	<u>H.C.Rep. 101-964</u>
Medicare - Supplementary Medical Insurance Benefits	1833(a) (7) New	4153(a) (2) (C) (iv)	1388- 83	79- 82, 235- 237, 265- 269	89, 743- 749
Medicare - Supplementary Medical Insurance Benefits	1833(b)	4302	1388- 125	91, 238, 273	133, 820- 821
Medicare - Supplementary Medical Insurance Benefits (technical amendment)	1833(b) (3)	4161(a) (3) (B) (i)	1388- 93	—	100, 752- 762
Medicare - Supplementary Medical Insurance Benefits (technical amendment)	1833(b) (4)	4161(a) (3) (B) (ii)	1388- 93	—	100, 752- 762
Medicare - Supplementary Medical Insurance Benefits	1833(b) (5) New	4161(a) (3) (B) (ii)	1388- 93	—	100, 752- 762
Medicare - Supplementary Medical Insurance Benefits	1833(h) (2) (A) (ii)	4154(a) (1)	1388- 84	82- 83, 237, 269- 270	90, 750- 751
Medicare - Supplementary Medical Insurance Benefits (technical amendment)	1833(h) (2) (A) (ii) (I)	4154(a) (2)	1388- 84	82- 83, 237, 269- 270	90, 750- 751
Medicare - Supplementary Medical Insurance Benefits (technical amendment)	1833(h) (2) (A) (ii) (II) New	4154(a) (3)	1388- 84	82- 83, 237, 269- 270	90, 750- 751
Medicare - Supplementary Medical Insurance Benefits	1833(h) (2) (A) (ii) (III) New	4154(a) (4)	1388- 84	82- 83, 237, 269- 270	90, 750- 751

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<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>104 Stat.</u>	<u>H. Rep. 101-881</u>	<u>H.C.Rep. 101-964</u>
Medicare - Supplementary Medical Insurance Benefits (technical amendment)	1833(h) (4) (B) (ii)	4154(b) (1) (A)	1388- 85	82- 83, 237, 269- 270	91, 750- 751
Medicare - Supplementary Medical Insurance Benefits	1833(h) (4) (B) (iii)	4154(b) (1) (B) (i)	1388- 85	82- 83, 237, 269- 270	91, 750- 751
Medicare - Supplementary Medical Insurance Benefits (technical amendment)	1833(h) (4) (B) (iii)	4154(b) (1) (B) (ii)	1388- 85	82- 83, 237, 269- 270	91, 750- 751
Medicare - Supplementary Medical Insurance Benefits	1833(h) (4) (B) (iv) New	4154(b) (1) (C)	1388- 85	82- 83, 237, 269- 270	91, 750- 751
Medicare - Supplementary Medical Insurance Benefits	1833(h) (5) (A) (ii) (II)	4154(e) (1) (A)	1388- 85	82- 83, 237, 269- 270	91, 750- 751
Medicare - Supplementary Medical Insurance Benefits	1833(h) (5) (A) (ii) (III)	4154(e) (1) (B)	1388- 85	82- 83, 237, 269- 270	91, 750- 751
Medicare - Supplementary Medical Insurance Benefits	1833(h) (5) (A) (ii) (III)	4154(e) (1) (C)	1388- 85	82- 83, 237, 269- 270	91, 750- 751
Medicare - Supplementary Medical Insurance Benefits	1833(h) (5) (C)	4154(c) (1) (A)	1388- 85	82- 83, 237, 269- 270	91, 750 751

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<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>104 Stat.</u>	<u>H. Rep. 101-881</u>	<u>H.C.Rep. 101-964</u>
Medicare - Supplementary Medical Insurance Benefits	1833(h) (5) (D)	4154(c) (1) (B)	1388- 85	82- 83, 237, 269- 270	91, 750- 751
Medicare - Supplementary Medical Insurance Benefits	1833(i) (3) (B) (ii) (I)	4151(c) (1) (A) (i)	1388- 85	77- 79, 234- 235, 262- 265	78, 739- 743
Medicare - Supplementary Medical Insurance Benefits	1833(i) (3) (B) (ii) (II)	4151(c) (1) (A) (ii)	1388- 85	77- 79, 234- 235, 262- 265	78, 739- 743
Medicare - Supplementary Medical Insurance Benefits	1833(i) (3) (B) (ii)	4151(c) (1) (B)	1388- 85	77- 79, 234- 235, 262- 265	78, 739- 743
Medicare - Supplementary Medical Insurance Benefits (technical amendment)	1833(1) (1) Redesignated as 1833(1) (1) (A)	4160(1) (A)	1388- 91	—	97, 752- 762
Medicare - Supplementary Medical Insurance Benefits	1833(1) (1) (B)	4160(1) (B)	1388- 91	—	97, 752- 762
Medicare - Supplementary Medical Insurance Benefits	1833(1) (1) (C) New	4160(1) (B)	1388- 91	—	97, 752- 762
Medicare - Supplementary Medical Insurance Benefits	1833(1) (2)	4160(2)	1388- 91	—	97, 752- 762
Medicare - Supplementary Medical Insurance Benefits	1833(1) (4)	4160(3)	1388- 91	—	97- 99, 752- 762

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<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>104 Stat.</u>	<u>H. Rep. 101-881</u>	<u>H.C.Rep. 101-964</u>
Medicare - Supplementary Medical Insurance Benefits	1833(n) (1) (B) (ii) (I)	4151(c) (2)	1388- 73	77- 79, 234- 235, 262- 265	79, 739- 743
Medicare - Supplementary Medical Insurance Benefits	1833(r) New	4155(b) (3)	1388- 87	83	93, 752- 763
Medicare - Supplementary Medical Insurance Benefits	1833(r) New	4206(b) (2)	1388- 116	--	124, 774- 778
Medicare - Supplementary Medical Insurance Benefits	1834(a)	4153(a) (2) (D) (i)	1388- 83	79- 82, 235- 237, 265- 269	89, 743- 749
Medicare - Supplementary Medical Insurance Benefits	1834(a) (1) (D) Heading	4152(a) (1)	1388- 74	79- 82, 235- 237, 265- 269	79, 743- 749
Medicare - Supplementary Medical Insurance Benefits	1834(a) (2) (A)	4153(a) (2) (D) (ii)	1388- 97	79- 82, 235- 237, 265- 269	89, 743- 749
Medicare - Supplementary Medical Insurance Benefits (technical amendment)	1834(a) (2) (A) (i)	4152(c) (4) (A) (i)	1388- 79	79- 82, 235- 237, 265- 269	84, 743- 749

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<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>104 Stat.</u>	<u>H. Rep. 101-881</u>	<u>H.C.Rep. 101-964</u>
Medicare - Supplementary Medical Insurance Benefits (technical amendment)	1834(a) (2) (A) (ii)	4152(c) (4) (A) (ii)	1388- 79	79- 82, 235- 237, 265- 269	84, 743- 749
Medicare - Supplementary Medical Insurance Benefits	1834(a) (2) (A) (iii) Stricken	4152(c) (4) (A) (iii)	1388- 79	79- 82, 235- 237, 265- 269	84, 743- 749
Medicare - Supplementary Medical Insurance Benefits (technical amendment)	1834(a) (2) (B) (i)	4152(b) (1) (A)	1388- 74	79- 82, 235- 237, 265- 269	79, 743- 749
Medicare - Supplementary Medical Insurance Benefits	1834(a) (2) (B) (ii)	4152(b) (1) (B)	1388- 74	79- 82, 235- 237, 265- 269	79, 743- 749
Medicare - Supplementary Medical Insurance Benefits	1834(a) (2) (B) (iii) New	4152(b) (1) (B)	1388- 74	79- 82, 235- 237, 265- 269	79, 743- 749
Medicare - Supplementary Medical Insurance Benefits	1834(a) (2) (B) (iv) New	4152(b) (1) (B)	1388- 74	79- 82, 235- 237, 265- 269	79, 743- 749

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<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>104 Stat.</u>	<u>H. Rep. 101-881</u>	<u>H.C.Rep. 101-964</u>
Medicare - Supplementary Medical Insurance Benefits	1834(a) (2) (C) New	4152(b) (1) (C)	1388- 74	79- 82, 235- 237, 265- 269	80, 743- 749
Medicare - Supplementary Medical Insurance Benefits (technical amendment)	1834(a) (3) (B) (i)	4152(b) (1) (A)	1388- 74	79- 82, 235- 237, 265- 269	79, 743- 749
Medicare - Supplementary Medical Insurance Benefits (technical amendment)	1834(a) (3) (B) (ii)	4152(b) (1) (B)	1388- 74	79- 82, 235- 237, 265- 269	79, 743- 749
Medicare - Supplementary Medical Insurance Benefits	1834(a) (3) (B) (iii) New	4152(b) (1) (B)	1388- 74	79- 82, 235- 237, 265- 269	79, 743- 749
Medicare - Supplementary Medical Insurance Benefits	1834(a) (3) (B) (iv) New	4152(b) (1) (B)	1388- 74	79- 82, 235- 237, 265- 269	79, 743- 749
Medicare - Supplementary Medical Insurance Benefits	1834(a) (3) (C) New	4152(b) (1) (C)	1388- 74	79- 82, 235- 237, 265- 269	80, 743- 749

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<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>104 Stat.</u>	<u>H. Rep. 101-881</u>	<u>H.C.Rep. 101-964</u>
Medicare - Supplementary Medical Insurance Benefits	1834 (a) (3) (D) New	4152 (c) (3)	1388- 78	79- 82, 235- 237, 265- 269	84, 743- 749
Medicare - Supplementary Medical Insurance Benefits	1834 (a) (4)	4152 (c) (4) (B) (i)	1388- 79	79- 82, 235- 237, 265- 269	84, 743- 749
Medicare - Supplementary Medical Insurance Benefits	1834 (a) (5) (A)	4152 (g) (1) (A)	1388- 80	79- 82, 235- 237, 265- 269	86, 743- 749
Medicare - Supplementary Medical Insurance Benefits	1834 (a) (5) (E) New	4152 (g) (1) (B)	1388- 80	79- 82, 235- 237, 265- 269	86, 743- 749
Medicare - Supplementary Medical Insurance Benefits	1834 (a) (7) (A) (i)	4152 (c) (1) (A)	1388- 77	79- 82, 235- 237, 265- 269	82, 743 749
Medicare - Supplementary Medical Insurance Benefits	1834 (a) (7) (A) (i)	4152 (c) (1) (B)	1388- 77	79- 82, 235- 237, 265- 269	82, 743- 749

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Subject	S.S. Act Section	P.L. Section	104 Stat.	H. Rep. 101-881	H.C.Rep. 101-964
Medicare - Supplementary Medical Insurance Benefits	1834 (a) (7) (A) (i)	4152 (c) (2) (A)	1388- 77	79- 82, 235- 237, 265- 269	82, 743- 749
Medicare - Supplementary Medical Insurance Benefits	1834 (a) (7) (A) (ii)	4152 (c) (2) (B) (i)	1388- 77	79- 82, 235- 237, 265- 269	82, 743- 749
Medicare - Supplementary Medical Insurance Benefits	1834 (a) (7) (A) (ii) New	4152 (c) (2) (D)	1388- 77	79- 82, 235- 237, 265- 269	83, 743- 749
Medicare - Supplementary Medical Insurance Benefits	1834 (a) (7) (A) (iii) New	4152 (c) (2) (D)	1388- 77	79- 82, 235- 237, 265- 269	83, 743- 749
Medicare - Supplementary Medical Insurance Benefits	1834 (a) (7) (A) (ii)	4152 (c) (2) (B) (ii)	1388- 77	79- 82, 235- 237, 265- 269	82, 743- 749
Medicare - Supplementary Medical Insurance Benefits	1834 (a) (7) (A) (iii)	4152 (c) (2) (C) (i)	1388- 77	79- 82, 235- 237, 265- 269	83, 743- 749

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<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>104 Stat.</u>	<u>H. Rep. 101-881</u>	<u>H.C.Rep. 101-964</u>
Medicare - Supplementary Medical Insurance Benefits	1834 (a) (7) (A) (iii)	4152 (c) (2) (C) (ii)	1388- 77	79- 82, 235- 237, 265- 269	83, 743- 749
Medicare - Supplementary Medical Insurance Benefits	1834 (a) (7) (A) (vi) New	4152 (c) (2) (E)	1388- 77	79- 82, 235- 237, 265- 269	83, 743- 749
Medicare - Supplementary Medical Insurance Benefits	1834 (a) (7) (C) New	4152 (c) (2) (F)	1388- 77	79- 82, 235- 237, 265- 269	83, 743 749
Medicare - Supplementary Medical Insurance Benefits	1834 (a) (8) (A) (ii) (I)	4152 (b) (2) (A) (i)	1388- 74	79- 82, 235- 237, 265- 269	80, 743- 749
Medicare - Supplementary Medical Insurance Benefits (technical amendment)	1834 (a) (8) (A) (ii) (II)	4152 (b) (2) (A) (ii) (I)	1388- 74	79- 82, 235- 237, 265- 269	80, 743- 749
Medicare - Supplementary Medical Insurance Benefits	1834 (a) (8) (A) (ii) (II)	4152 (b) (2) (A) (ii) (II)	1388- 74	79- 82, 235- 237, 265- 269	80, 743- 749

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Subject	S.S. Act Section	P.L. Section	104 Stat.	H. Rep. 101-881	H.C.Rep. 101-964
Medicare - Supplementary Medical Insurance Benefits (technical amendment)	1834(a)(8)(A)(ii) (II) Redesignated as 1834(a)(8)(A)(ii) (III)	4152(b)(2) (A)(iii)	1388- 74	79- 82, 235- 237, 265- 269	80, 743- 749
Medicare - Supplementary Medical Insurance Benefits	1834(a)(8)(A)(ii) (II) New	4152(b)(2) (A)(iv)	1388- 74	79- 82, 235- 237, 265- 269	80, 743- 749
Medicare - Supplementary Medical Insurance Benefits	1834(a)(8)(B)	4152(b)(2) (B)	1388- 74	79- 82, 235- 237, 265- 269	80, 743- 749
Medicare - Supplementary Medical Insurance Benefits	1834(a)(8)(C)	4152(b)(2) (C)(i)	1388- 74	79- 82, 235- 237, 265- 269	81, 743- 749
Medicare - Supplementary Medical Insurance Benefits	1834(a)(8)(C)	4152(b)(2) (C)(ii)	1388- 74	79- 82, 235- 237, 265- 269	81, 743- 749
Medicare - Supplementary Medical Insurance Benefits	1834(a)(8)(C)(ii)	4152(b)(2) (C)(iii)(I)	1388- 74	79- 82, 235- 237, 265- 269	81, 743- 749

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<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>104 Stat.</u>	<u>H. Rep. 101-881</u>	<u>H.C.Rep. 101-964</u>
Medicare - Supplementary Medical Insurance Benefits	1834(a) (8) (C) (ii)	4152(b) (2) (C) (iii) (II)	1388- 74	79- 82, 235- 237, 265- 269	81, 743- 749
Medicare - Supplementary Medical Insurance Benefits	1834(a) (8) (C) (iii) (I)	4152(b) (2) (C) (iv) (I)	1388- 74	79- 82, 235- 237, 265- 269	81, 743- 749
Medicare - Supplementary Medical Insurance Benefits	1834(a) (8) (C) (iii) (II)	4152(b) (2) (C) (iv) (II)	1388- 74	79- 82, 235- 237, 265- 269	81, 743- 749
Medicare - Supplementary Medical Insurance Benefits	1834(a) (8) (D) Stricken	4152(b) (2) (D)	1388- 74	79- 82, 235- 237, 265- 269	81, 743- 749
Medicare - Supplementary Medical Insurance Benefits	1834(a) (9) (A) (ii) (II)	4152(b) (3) (A)	1388- 74	79- 82, 235- 237, 265- 269	81, 743- 749
Medicare - Supplementary Medical Insurance Benefits	1834(a) (9) (B)	4152(b) (3) (B)	1388- 74	79- 82, 235- 237, 265- 269	81, 743- 749

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Subject	S.S. Act Section	P.L. Section	104 Stat.	H. Rep. 101-881	H.C.Rep. 101-964
Medicare - Supplementary Medical Insurance Benefits	1834 (a) (9) (C)	4152 (b) (3) (C) (i)	1388- 74	79- 82, 235- 237, 265- 269	81- 82, 743- 749
Medicare - Supplementary Medical Insurance Benefits	1834 (a) (9) (C) (ii)	4152 (b) (3) (C) (ii) (I)	1388- 74	79- 82, 235- 237, 265- 269	82, 743- 749
Medicare - Supplementary Medical Insurance Benefits	1834 (a) (9) (C) (ii)	4152 (b) (3) (C) (ii) (II)	1388- 74	79- 82, 235- 237, 265- 269	82, 743- 749
Medicare - Supplementary Medical Insurance Benefits	1834 (a) (9) (C) (iii) (I)	4152 (b) (3) (C) (iii) (I)	1388- 74	79- 82, 235- 237, 265- 269	82, 743- 749
Medicare - Supplementary Medical Insurance Benefits	1834 (a) (9) (C) (iii) (II)	4152 (b) (3) (C) (iii) (II)	1388- 74	79- 82, 235- 237, 265- 269	82, 743- 749
Medicare - Supplementary Medical Insurance Benefits	1834 (a) (9) (D) Stricken	4152 (b) (3) (D)	1388- 74	79- 82, 235- 237, 265- 269	82, 743- 749

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<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>104 Stat.</u>	<u>H. Rep. 101-881</u>	<u>H.C.Rep. 101-964</u>
Medicare - Supplementary Medical Insurance Benefits	1834(a) (12)	4152(b) (5)	1388- 74	79- 82, 235- 237, 265- 269	82, 743- 749
Medicare - Supplementary Medical Insurance Benefits	1834(a) (13)	4153(a) (2) (D) (iii)	1388- 83	79- 82, 235- 237, 265- 269	89, 743- 749
Medicare - Supplementary Medical Insurance Benefits	1834(a) (14) New	4152(b) (4)	1388- 74	79- 82, 235- 237, 265- 269	82, 743- 749
Medicare - Supplementary Medical Insurance Benefits	1834(a) (15) New	4152(e)	1388- 79	79- 82, 235- 237, 265- 269	85, 743- 749
Medicare - Supplementary Medical Insurance Benefits	1834(a) (16) New	4152(f) (1)	1388- 80	79- 82, 235- 237, 265- 269	85- 86, 743- 749
Medicare - Supplementary Medical Insurance Benefits	1834(b) (1) (B)	4102(f)	1388- 57	71- 72, 232- 233, 254- 258	61, 719- 728
Medicare - Supplementary Medical Insurance Benefits	1834(b) (1) (B)	4163(b) (1)	1388- 97	--	103, 763- 765

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<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>104 Stat.</u>	<u>H. Rep. 101-881</u>	<u>H.C.Rep. 101-964</u>
Medicare - Supplementary Medical Insurance Benefits (technical amendment)	1834(b) (4) (D) Redesignated as 1834(b) (4) (E)	4102(a) (1)	1388- 55	71- 72, 232- 233, 254- 258	59, 719- 728
Medicare - Supplementary Medical Insurance Benefits	1834(b) (4) (D) New	4102(a) (2)	1388- 55	71- 72, 232- 233, 254- 258	59- 61, 719- 728
Medicare - Supplementary Medical Insurance Benefits (technical amendment)	1834(b) (4) (E) Redesignated as 1834(b) (4) (F)	4102(a) (1)	1388- 55	71- 72, 232- 233, 254- 258	59, 719- 728
Medicare - Supplementary Medical Insurance Benefits	1834(b) (4) (E) New	4102(d)	1388- 57	71- 72, 232- 233, 254- 258	61, 719- 728
Medicare - Supplementary Medical Insurance Benefits	1834(c) New	4163(b) (2)	1388- 97	--	103- 106, 763- 765
Medicare - Supplementary Medical Insurance Benefits	1834(f)	4104(a)	1388- 59	72- 73, 232- 233, 254- 258	63, 719- 728
Medicare - Supplementary Medical Insurance Benefits	1834(h) New	4153(a) (1)	1388- 81	79- 82, 235- 237, 265- 269	86- 89, 743- 749

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<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>104 Stat.</u>	<u>H. Rep. 101-881</u>	<u>H.C.Rep. 101-964</u>
Medicare - Supplementary Medical Insurance Benefits	1835(c)	4008(m) (2) (D) (i)	1388- 53	—	57, 711- 717
Medicare - Supplementary Medical Insurance Benefits	1835(c)	4008(m) (2) (D) (ii)	1388- 53	—	57, 711- 717
Medicare - Supplementary Medical Insurance Benefits	1835(c)	4008(m) (2) (D) (iii)	1388- 53	—	57, 711- 717
Medicare - Supplementary Medical Insurance Benefits (technical amendment)	1839(e) (1) Redesignated as 1839(e) (1) (A)	4301(1)	1388- 125	91, 238, 272- 273	133, 819- 820
Medicare - Supplementary Medical Insurance Benefits	1839(e) (1) (B) New	4301(2)	1388- 125	91, 238, 272- 273	133, 819- 820
Medicare - Supplementary Medical Insurance Benefits	1842(b) (2) (A)	4118(j) (2)	1388- 71	—	76, 752- 763
Medicare - Supplementary Medical Insurance Benefits	1842(b) (3) (G)	4118(f) (2) (B)	1388- 69	—	74, 752- 763
Medicare - Supplementary Medical Insurance Benefits	1842(b) (4) (A) (vi)	4105(b) (1)	1388- 60	73- 74, 233- 234, 258- 260	64, 729- 732
Medicare - Supplementary Medical Insurance Benefits	1842(b) (4) (B) (iv) New	4105(a) (2)	1388- 59	73- 74, 233- 234, 258- 260	64, 729- 732
Medicare - Supplementary Medical Insurance Benefits	1842(b) (4) (E) (iv) (I)	4118(a) (2)	1388- 67	—	72, 752- 763

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<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>104 Stat.</u>	<u>H. Rep. 101-881</u>	<u>H.C.Rep. 101-964</u>
Medicare - Supplementary Medical Insurance Benefits	1842(b) (4) (E) (v) New	4105(a) (1)	1388- 59	73- 74, 233- 234, 258- 260	64, 729- 732
Medicare - Supplementary Medical Insurance Benefits	1842(b) (4) (F)	4106(a) (1)	1388- 61	74, 234, 260- 262	65- 66, 732- 739
Medicare - Supplementary Medical Insurance Benefits	1842(b) (4) (F) (i)	4106(b) (2) (A)	1388- 62	74, 234, 260- 262	66, 732- 739
Medicare - Supplementary Medical Insurance Benefits	1842(b) (4) (F) (i)	4106(b) (2) (B)	1388- 62	74, 234, 260- 262	66, 732- 739
Medicare - Supplementary Medical Insurance Benefits	1842(b) (4) (F) (ii) (II)	4106(b) (2) (C)	1388- 62	74, 234, 260- 262	66, 732- 739
Medicare - Supplementary Medical Insurance Benefits (technical amendment)	1842(b) (6)	4110(a) (1)	1388- 63	75	68, 732- 739
Medicare - Supplementary Medical Insurance Benefits	1842(b) (6)	4110(a) (2)	1388- 63	75	68, 732- 739
Medicare - Supplementary Medical Insurance Benefits	1842(b) (6) (D) New	4110(a) (2)	1388- 63	—	68, 732- 739
Medicare - Supplementary Medical Insurance Benefits	1842(b) (6)	4155(c)	1388- 87	—	93, 752- 763
Medicare - Supplementary Medical Insurance Benefits	1842(b) (12)	4155(c)	1388- 87	—	93, 752- 763

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Subject	S.S. Act Section	P.L. Section	104 Stat.	H. Rep. 101-881	H.C.Rep. 101-964
Medicare - Supplementary Medical Insurance Benefits	1842(b) (12) (A) (ii) (II)	4118(f) (2) (C)	1388- 69	—	74, 752- 763
Medicare - Supplementary Medical Insurance Benefits	1842(b) (13)	4103(b)	1388- 58	72, 232- 233, 258	63, 719- 728
Medicare - Supplementary Medical Insurance Benefits (technical amendment)	1842(b) (14) (A) Redesignated as 1842(b) (14) (A) (i)	4101(a) (1)	1388- 54	70- 71, 232- 233, 254- 258	58, 719- 728
Medicare - Supplementary Medical Insurance Benefits	1842(b) (14) (A) (ii) New	4101(a) (2)	1388- 54	70- 71, 232- 233, 254- 258	58, 719- 728
Medicare - Supplementary Medical Insurance Benefits	1842(b) (14) (B) (iii) (I)	4118(a) (1) (A)	1388- 66	—	71, 752- 763
Medicare - Supplementary Medical Insurance Benefits	1842(b) (14) (B) (iii) (II)	4118(a) (1) (B)	1388- 66	—	71, 752- 763
Medicare - Supplementary Medical Insurance Benefits	1842(b) (14) (C) (i)	4118(a) (1) (C)	1388- 66	—	71, 752- 763
Medicare - Supplementary Medical Insurance Benefits	1842(b) (14) (C) (iii)	4118(a) (1) (D)	1388- 66	—	71, 752- 763
Medicare - Supplementary Medical Insurance Benefits	1842(b) (14) (C) (iv)	4118(a) (1) (E)	1388- 66	—	71, 752- 763

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<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>104 Stat.</u>	<u>H. Rep. 101-881</u>	<u>H.C.Rep. 101-964</u>
Medicare - Supplementary Medical Insurance Benefits	1842(b) (16) New	4101(b) (1)	1388- 54	70- 71, 232- 233, 254- 258	58- 59, 719- 728
Medicare - Supplementary Medical Insurance Benefits	1842(b) (18) New	4108(a)	1388- 63	74- 75	67, 732- 739
Medicare - Supplementary Medical Insurance Benefits (technical amendment)	1842(q) (1) Redesignated as 1842(q) (1) (A)	4103(a) (1)	1388- 58	72, 232- 233, 254- 258	62, 719- 728
Medicare - Supplementary Medical Insurance Benefits	1842(q) (1) (B) New	4103(a) (2)	1388- 58	72, 232- 233, 254- 258	62, 719- 728
Medicare - Supplementary Medical Insurance Benefits	1842(r) New	4118(i) (1)	1388- 70	—	75, 752- 763
Medicare - Supplementary Medical Insurance Benefits	1843(h) (3) New	4501(d)	1388- 165	101- 102	175, 835- 837
Medicare - Supplementary Medical Insurance Benefits	1845(a) (3)	4118(j) (1) (A)	1388- 70	—	75, 752- 763
Medicare - Supplementary Medical Insurance Benefits	1845(b) (2) (A) Stricken	4118(j) (1) (C) (iii)	1388- 70	—	75, 752- 763
Medicare - Supplementary Medical Insurance Benefits	1845(b) (2) (B) Stricken	4118(j) (1) (C) (iii)	1388- 70	—	75, 752- 763
Medicare - Supplementary Medical Insurance Benefits	1845(b) (2) (C) Stricken	4118(j) (1) (C) (iii)	1388- 70	—	75, 752- 763

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<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>104 Stat.</u>	<u>H. Rep. 101-881</u>	<u>H.C.Rep. 101-964</u>
Medicare - Supplementary Medical Insurance Benefits (technical amendment)	1845(b) (2) (D) Redesignated as 1845(b) (2) (A)	4118(j) (1) (C) (iv)	1388- 70	—	75, 752- 763
Medicare - Supplementary Medical Insurance Benefits (technical amendment)	1845(b) (2) (E) Redesignated as 1845(b) (2) (B)	4118(j) (1) (C) (iv)	1388- 70	—	75, 752- 763
Medicare - Supplementary Medical Insurance Benefits	1845(b) (2) (F) Stricken	4118(j) (1) (C) (iii)	1388- 70	—	75, 752- 763
Medicare - Supplementary Medical Insurance Benefits	1845(b) (2) (F) New	4118(j) (1) (C) (v)	1388- 70	—	76, 752- 763
Medicare - Supplementary Medical Insurance Benefits (technical amendment)	1845(b) (2) (G) Redesignated as 1845(b) (2) (C)	4118(j) (1) (C) (iv)	1388- 70	—	75, 752- 763
Medicare - Supplementary Medical Insurance Benefits	1845(b) (2) (G) New	4118(j) (1) (C) (v)	1388- 70	—	76, 752- 763
Medicare - Supplementary Medical Insurance Benefits (technical amendment)	1845(b) (2) (H)	4118(j) (1) (C) (i)	1388- 70	—	75, 752- 763
Medicare - Supplementary Medical Insurance Benefits (technical amendment)	1845(b) (2) (H) Redesignated as 1845(b) (2) (D)	4118(j) (1) (C) (iv)	1388- 70	—	75, 752- 763
Medicare - Supplementary Medical Insurance Benefits	1845(b) (2) (H) New	4118(j) (1) (C) (v)	1388- 70	—	76, 752- 763
Medicare - Supplementary Medical Insurance Benefits (technical amendment)	1845(b) (2) (I)	4118(j) (1) (C) (ii)	1388- 70	—	75, 752- 763
Medicare - Supplementary Medical Insurance Benefits (technical amendment)	1845(b) (2) (I) Redesignated as 1845(b) (2) (E)	4118(j) (1) (C) (iv)	1388- 70	—	75, 752- 763
Medicare - Supplementary Medical Insurance Benefits	1845(b) (2) (I) New	4118(j) (1) (C) (v)	1388- 70	—	76, 752- 763

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Subject	S.S. Act Section	P.L. Section	104 Stat.	H. Rep. 101-881	H.C.Rep. 101-964
Medicare - Supplementary Medical Insurance Benefits	1845(b) (2) (J) New	4118(j) (1) (C) (v)	1388- 70	—	76, 752- 763
Medicare - Supplementary Medical Insurance Benefits	1845(b) (2) (K) New	4118(j) (1) (C) (v)	1388- 70	—	76, 752- 763
Medicare - Supplementary Medical Insurance Benefits	1845(b) (2) (L) New	4118(j) (1) (C) (v)	1388- 70	—	76, 752- 763
Medicare - Supplementary Medical Insurance Benefits	1845(b) (2) (M) New	4118(j) (1) (C) (v)	1388- 70	—	76, 752- 763
Medicare - Supplementary Medical Insurance Benefits	1845(b) (3) Stricken	4118(j) (1) (B)	1388- 70	—	75, 752- 763
Medicare - Supplementary Medical Insurance Benefits (conforming amendment)	1845(c) (1) (D)	4002(g) (3)	1388- 37	246- 250	40, 693- 700
Medicare - Supplementary Medical Insurance Benefits	1845(e) Stricken	4118(j) (1) (D)	1388- 70	—	76, 752- 763
Medicare - Supplementary Medical Insurance Benefits (technical amendment)	1845(f) Redesignated as 1845(e)	4118(j) (1) (D)	1388- 70	—	76, 752- 763
Medicare - Supplementary Medical Insurance Benefits	1846	4154 (e) (2)	1388- 86	82- 83, 237, 269- 270	92, 750- 751
Medicare - Supplementary Medical Insurance Benefits (conforming amendment)	1848(a) (1)	4104 (b) (2)	1388- 56	72- 73, 232- 233, 254- 258	63, 719- 728

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<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>104 Stat.</u>	<u>H. Rep. 101-881</u>	<u>H.C.Rep. 101-964</u>
Medicare - Supplementary Medical Insurance Benefits	1848(a) (2) (C)	4102(b) (1)	1388- 56	71- 72, 232- 233, 254- 258	61, 719- 728
Medicare - Supplementary Medical Insurance Benefits	1848(a) (2) (C)	4102(b) (2)	1388- 56	71- 72, 232- 233, 254- 258	61, 719- 728
Medicare - Supplementary Medical Insurance Benefits	1848(a) (2) (D) (ii)	4102(g) (2) (A)	1388- 57	71- 72, 232- 233, 254- 258	62, 719- 728
Medicare - Supplementary Medical Insurance Benefits	1848(a) (2) (D) (iii) New	4102(g) (2) (B)	1388- 57	71- 72, 232- 233, 254- 258	62, 719- 728
Medicare - Supplementary Medical Insurance Benefits	1848(a) (4) New	4106(b) (1)	1388- 61	234, 260- 262	66, 732- 739
Medicare - Supplementary Medical Insurance Benefits	1848(b) (3) New	4109(a)	1388- 63	234, 260- 262	68, 732- 739
Medicare - Supplementary Medical Insurance Benefits	1848(c) (1) (B)	4118(f) (1) (A)	1388- 68	—	72, 752- 763
Medicare - Supplementary Medical Insurance Benefits	1848(c) (3) (C) (ii) (II)	4118(f) (1) (B)	1388- 68	—	72, 752- 763
Medicare - Supplementary Medical Insurance Benefits	1848(c) (3) (C) (iii) (II)	4118(f) (1) (B)	1388- 68	—	72, 752- 763

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<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>104 Stat.</u>	<u>H. Rep. 101-881</u>	<u>H.C.Rep. 101-964</u>
Medicare - Supplementary Medical Insurance Benefits (technical amendment)	1848(c) (3) Redesignated as 1848(c) (4)	4118(f) (1) (C)	1388- 68	—	73, 752- 763
Medicare - Supplementary Medical Insurance Benefits	1848(c) (4)	4118(d)	1388- 67	—	72, 752- 763
Medicare - Supplementary Medical Insurance Benefits (technical amendment)	1848(c) (4) Redesignated as 1848(c) (5)	4118(f) (1) (C)	1388- 68	—	73, 752- 763
Medicare - Supplementary Medical Insurance Benefits	1848(c) (4)	4118(f) (1) (D)	1388- 68	—	73, 752- 763
Medicare - Supplementary Medical Insurance Benefits (technical amendment)	1848(c) (5) Redesignated as 1848(c) (6)	4118(f) (1) (C)	1388- 68	—	73, 752- 763
Medicare - Supplementary Medical Insurance Benefits	1848(d) (1) (A)	4118(f) (1) (E)	1388- 68	—	73, 752- 763
Medicare - Supplementary Medical Insurance Benefits	1848(d) (1) (A)	4118(f) (1) (F) (i) (I)	1388- 68	—	73, 752- 763
Medicare - Supplementary Medical Insurance Benefits	1848(d) (1) (A)	4118(f) (1) (F) (i) (II)	1388- 68	—	73, 752- 763
Medicare - Supplementary Medical Insurance Benefits	1848(d) (1) (A)	4118(f) (1) (F) (i) (III)	1388- 68	—	73, 752- 763
Medicare - Supplementary Medical Insurance Benefits	1848(d) (1) (C) (i)	4118(f) (1) (F) (ii) (I)	1388- 68	—	73, 752- 763
Medicare - Supplementary Medical Insurance Benefits	1848(d) (1) (C) (ii)	4118(f) (1) (F) (ii) (II)	1388- 68	—	73, 752- 763
Medicare - Supplementary Medical Insurance Benefits	1848(d) (2) (A)	4118(f) (1) (G)	1388- 68	—	73, 752- 763

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<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>104 Stat.</u>	<u>H. Rep. 101-881</u>	<u>H.C.Rep. 101-964</u>
Medicare - Supplementary Medical Insurance Benefits	1848(d) (2) (A) (ii)	4118(f) (1) (H) (i)	1388- 68	—	73, 752- 763
Medicare - Supplementary Medical Insurance Benefits	1848(d) (2) (A) (ii)	4118(f) (1) (H) (ii)	1388- 68	—	73, 752- 763
Medicare - Supplementary Medical Insurance Benefits	1848(d) (2) (A)	4118(f) (1) (I)	1388- 68	—	73, 752- 763
Medicare - Supplementary Medical Insurance Benefits	1848(d) (2) (E) (i)	4118(f) (1) (J)	1388- 68	—	73, 752- 763
Medicare - Supplementary Medical Insurance Benefits	1848(d) (2) (E) (ii) (I)	4118(f) (1) (K)	1388- 68	—	73, 752- 763
Medicare - Supplementary Medical Insurance Benefits	1848(d) (3) (A) (i)	4105(a) (3) (A)	1388- 60	73- 74, 233- 234, 258- 260	64, 729- 732
Medicare - Supplementary Medical Insurance Benefits	1848(d) (3) (A) (iii) New	4105(a) (3) (B)	1388- 60	73- 74, 233- 234, 258- 260	64, 729- 732
Medicare - Supplementary Medical Insurance Benefits	1848(d) (3) (B) (i)	4118(f) (1) (L) (i) (I)	1388- 68	—	73, 752- 763
Medicare - Supplementary Medical Insurance Benefits	1848(d) (3) (B) (i)	4118(f) (1) (L) (i) (II)	1388- 68	—	73, 752- 763
Medicare - Supplementary Medical Insurance Benefits	1848(d) (3) (B) (ii)	4118(f) (1) (L) (ii) (I)	1388- 68	—	73, 752- 763

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<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>104 Stat.</u>	<u>H. Rep. 101-881</u>	<u>H.C.Rep. 101-964</u>
Medicare - Supplementary Medical Insurance Benefits	1848(d) (3) (B) (ii) (I)	4118(f) (1) (L) (ii) (II)	1388- 68	—	73, 752- 763
Medicare - Supplementary Medical Insurance Benefits	1848(e) (1) (A)	4118(c) (1)	1388- 67	—	72, 752- 763
Medicare - Supplementary Medical Insurance Benefits	1848(e) (1) (C) New	4118(c) (2)	1388- 67	—	72, 752- 763
Medicare - Supplementary Medical Insurance Benefits	1848(f) (1) (C)	4105(c) (1)	1388- 60	73- 74, 233- 234, 258- 260	65, 729- 732
Medicare - Supplementary Medical Insurance Benefits	1848(f) (1) (D) (i)	4118(f) (1) (M)	1388- 68	—	74, 752- 763
Medicare - Supplementary Medical Insurance Benefits	1848(f) (2) (A)	4118(f) (1) (N) (i)	1388- 68	—	74, 752- 763
Medicare - Supplementary Medical Insurance Benefits	1848(f) (2) (A)	4118(b) (1)	1388- 67	—	72, 752- 763
Medicare - Supplementary Medical Insurance Benefits	1848(f) (2) (A) (i)	4118(b) (2)	1388- 67	—	72, 752- 763
Medicare - Supplementary Medical Insurance Benefits	1848(f) (2) (A) (i)	4118(b) (3)	1388- 67	—	72, 752- 763
Medicare - Supplementary Medical Insurance Benefits	1848(f) (2) (A) (i)	4118(f) (1) (M)	1388- 68	—	74, 752- 763
Medicare - Supplementary Medical Insurance Benefits	1848(f) (2) (A) (i)	4118(f) (1) (N) (ii)	1388- 68	—	74, 752- 763

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<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>104 Stat.</u>	<u>H. Rep. 101-881</u>	<u>H.C.Rep. 101-964</u>
Medicare - Supplementary Medical Insurance Benefits	1848(f) (2) (A) (ii)	4118(b) (2)	1388- 67	---	72, 752- 763
Medicare - Supplementary Medical Insurance Benefits	1848(f) (2) (A) (ii)	4118(b) (4)	1388- 67	---	72, 752- 763
Medicare - Supplementary Medical Insurance Benefits	1848(f) (2) (A) (iii)	4118(b) (2)	1388- 67	---	72, 752- 763
Medicare - Supplementary Medical Insurance Benefits	1848(f) (2) (A) (iii)	4118(b) (5)	1388- 67	---	72, 752- 763
Medicare - Supplementary Medical Insurance Benefits	1848(f) (2) (A) (iii)	4118(f) (1) (N) (iii)	1388- 68	---	74, 752- 763
Medicare - Supplementary Medical Insurance Benefits	1848(f) (2) (A) (iv)	4118(b) (2)	1388- 67	---	72, 752- 763
Medicare - Supplementary Medical Insurance Benefits	1848(f) (2) (A) (iv)	4118(b) (4)	1388- 67	---	72, 752- 763
Medicare - Supplementary Medical Insurance Benefits	1848(f) (2) (A) (iv)	4118(e)	1388- 68	---	72, 752- 763
Medicare - Supplementary Medical Insurance Benefits	1848(f) (2) (A) (iv)	4118(f) (1) (N) (iv)	1388- 68	---	74, 752- 763
Medicare - Supplementary Medical Insurance Benefits	1848(f) (2) (A)	4118(b) (6)	1388- 67	---	72, 752- 763
Medicare - Supplementary Medical Insurance Benefits	1848(f) (2) (C) New	4105(c) (2)	1388- 60	73- 74, 233- 234, 258- 260	65, 729- 732

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<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>104 Stat.</u>	<u>H. Rep. 101-881</u>	<u>H.C.Rep. 101-964</u>
Medicare - Supplementary Medical Insurance Benefits	1848(f) (4) (A)	4118(f) (1) (O)	1388- 68	—	74, 752- 763
Medicare - Supplementary Medical Insurance Benefits	1848(f) (4) (B)	4118(f) (1) (P)	1388- 68	—	74, 752- 763
Medicare - Supplementary Medical Insurance Benefits	1848(g) (2) (A)	4116	1388- 65	—	70, 732- 739
Medicare - Supplementary Medical Insurance Benefits	1848(g) (2) (A)	4118(f) (1) (Q)	1388- 68	—	74, 752- 763
Medicare - Supplementary Medical Insurance Benefits	1848(g) (2) (B)	4118(f) (1) (Q)	1388- 68	—	74, 752- 763
Medicare - Supplementary Medical Insurance Benefits	1848(i) (1) (A)	4118(f) (1) (R)	1388- 68	—	74, 752- 763
Medicare - Supplementary Medical Insurance Benefits	1848(i) (2) New	4107(a) (1)	1388- 62	234, 260- 262	67, 732- 739
Medicare - Supplementary Medical Insurance Benefits	1848(i) (3) New	4118(k)	1388- 71	—	76, 752- 763
Medicare - Supplementary Medical Insurance Benefits	1848(j) (1)	4118(f) (1) (S)	1388- 68	—	76, 752- 763
Medicare - Definitions - Inpatient Hospital Services	1861(b) (3)	4157(a) (1)	1388- 88	—	95, 752- 762
Medicare - Definitions - Inpatient Hospital Services	1861(b) (4)	4157(a) (2)	1388- 88	—	95, 752- 762

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<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>104 Stat.</u>	<u>H. Rep. 101-881</u>	<u>H.C.Rep. 101-964</u>
Medicare - Definitions - Durable Medical Equipment	1861(n)	4152(a) (2)	1388- 74	79- 82, 235- 237, 265- 269	79, 743- 749
Medicare - Definitions - Medical and Other Health Services	1861(s) (2) (E)	4161(a) (1)	1388- 93	—	99, 752- 762
Medicare - Definitions - Medical and Other Health Services (conforming amendment)	1861(s) (2) (H) (i)	4161(a) (5) (A)	1388- 94	—	100, 752- 762
Medicare - Definitions - Medical and Other Health Services	1861(s) (2) (K)	4161(a) (5) (A)	1388- 94	—	100, 752- 762
Medicare - Definitions - Medical and Other Health Services (technical amendment)	1861(s) (2) (K) (ii)	4155(a) (1)	1388- 86	83	92, 752- 763
Medicare - Definitions - Medical and Other Health Services (technical amendment)	1861(s) (2) (K) (ii) Redesignated as 1861(s) (2) (K) (iii)	4155(a) (2)	1388- 86	83	92, 752- 763
Medicare - Definitions - Medical and Other Health Services	1861(s) (2) (K) (iii) New	4155(a) (3)	1388- 86	83	92, 752- 763
Medicare - Definitions - Medical and Other Health Services (technical amendment)	1861(s) (2) (M)	4156(a) (1) (A)	1388- 88	84	94, 752- 763
Medicare - Definitions - Medical and Other Health Services (technical amendment)	1861(s) (2) (N)	4156(a) (1) (B)	1388- 88	84	94, 752- 763

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<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>104 Stat.</u>	<u>H. Rep. 101-881</u>	<u>H.C.Rep. 101-964</u>
Medicare - Definitions - Medical and Other Health Services	1861(s) (2) (N)	4201(d) (1) (A)	1388- 104	87, 237, 270- 271	111, 765- 771
Medicare - Definitions - Medical and Other Health Services	1861(s) (2) (O) New	4156(a) (1) (C)	1388- 88	—	94, 752- 763
Medicare - Definitions - Medical and Other Health Services (technical amendment)	1861(s) (2) (O)	4201(d) (1) (B)	1388- 104	87, 237, 270- 271	111, 765- 771
Medicare - Definitions - Medical and Other Health Services	1861(s) (2) (P) New	4201(d) (1) (C)	1388- 104	87, 237, 270- 271	111, 765- 771
Medicare - Definitions - Medical and Other Health Services	1861(s) (8)	4153(b) (2) (A)	1388- 84	79- 82, 235- 237, 265- 269	90, 743- 749
Medicare - Definitions - Medical and Other Health Services	1861(s) (11)	4163(a) (1) (A)	1388- 96	—	103, 763- 765
Medicare - Definitions - Medical and Other Health Services	1861(s) (12) (C)	4163(a) (1) (B)	1388- 96	—	103, 763- 765
Medicare - Definitions - Medical and Other Health Services	1861(s) (13) New	4163(a) (1) (C)	1388- 96	—	103, 763- 765
Medicare - Definitions - Reasonable Cost	1861(v) (1) (E)	4008(h) (2) (A) (i)	1388- 48	—	52, 706- 714
Medicare - Definitions - Reasonable Cost	1861(v) (1) (L) (iii)	4027(d) (1)	1388- 120	—	128, 810- 819

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<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>104 Stat.</u>	<u>H. Rep. 101-881</u>	<u>H.C.Rep. 101-964</u>
Medicare - Definitions - Reasonable Cost	1861(v) (1) (S) (ii) (I)	4151(a) (1)	1388- 71	77- 79, 234- 235, 262- 265	76- 77, 739- 743
Medicare - Definitions - Reasonable Cost	1861(v) (1) (S) (ii) (II)	4151(a) (2)	1388- 71	77- 79, 234- 235, 262- 265	76- 77, 739- 743
Medicare - Definitions - Reasonable Cost	1861(v) (1) (S) (ii) (II)	4151(b) (1) (A) (i)	1388- 72	77- 79, 234- 235, 262- 265	77, 739- 743
Medicare - Definitions - Reasonable Cost	1861(v) (1) (S) (ii) (II)	4151(b) (1) (A) (ii)	1388- 72	77- 79, 234- 235, 262- 265	77, 739- 743
Medicare - Definitions - Reasonable Cost (technical amendment)	1861(v) (1) (S) (ii) (II) Redesignated as 1861(v) (1) (S) (ii) (III)	4151(b) (1) (C)	1388- 72	77- 79, 234- 235, 262- 265	77, 739- 743
Medicare - Definitions - Reasonable Cost	1861(v) (1) (S) (ii) (II) New	4151(b) (1) (D)	1388- 72	77- 79, 234- 235, 262- 265	77, 739- 743

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<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>104 Stat.</u>	<u>H. Rep. 101-881</u>	<u>H.C.Rep. 101-964</u>
Medicare - Definitions - Reasonable Cost	1861(v) (1) (S) (ii) (III)	4151(b) (1) (B) (i)	1388- 72	77- 79, 234- 235, 262- 265	77, 739- 743
Medicare - Definitions - Reasonable Cost	1861(v) (1) (S) (ii) (III)	4151(b) (1) (B) (ii)	1388- 72	77- 79, 234- 235, 262- 265	77, 739- 743
Medicare - Definitions - Reasonable Cost (technical amendment)	1861(v) (1) (S) Redesignated as 1861(v) (1) (S) (ii) (IV)	4151(b) (1) (C)	1388- 72	77- 79, 234- 235, 262- 265	77, 739- 743
Medicare - Definitions - Rural Health Clinics	1861(aa)	4161(a) (2) (A)	1388- 93	—	99, 752- 762
Medicare - Definitions - Rural Health Clinics	1861(aa) (1) (B)	4161(a) (5) (B)	1388- 94	—	100, 752- 762
Medicare - Definitions - Rural Health Clinics	1861(aa) (2)	4161(b) (1)	1388- 95	—	101, 752- 762
Medicare - Definitions - Rural Health Clinics	1861(aa) (3)	4155(d)	1388- 87	83	94, 752- 763
Medicare - Definitions - Rural Health Clinics	1861(aa) (3)	4161(a) (2) (B)	1388- 93	—	99, 752- 762
Medicare - Definitions - Rural Health Clinics (technical amendment)	1861(aa) (3) Redesignated as 1861(aa) (5)	4161(a) (2) (B)	1388- 93	—	99, 752- 762

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<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>104 Stat.</u>	<u>H. Rep. 101-881</u>	<u>H.C.Rep. 101-964</u>
Medicare - Definitions - Rural Health Clinics	1861(aa) (3) New	4161(a) (2) (C)	1388- 93	—	99, 752- 762
Medicare - Definitions - Rural Health Clinics (technical amendment)	1861(aa) (4) Redesignated as 1861(aa) (6)	4161(a) (2) (B)	1388- 93	—	99, 752- 762
Medicare - Definitions - Rural Health Clinics	1861(aa) (4) New	4161(a) (2) (C)	1388- 93	—	99- 100, 752- 762
Medicare - Definitions - Rural Health Clinics	1861(aa) (7) New	4161(b) (2)	1388- 95	—	101- 102, 752- 762
Medicare - Definitions - Partial Hospitalization (technical amendment)	1861(ff) (3) Redesignated as 1861(ff) (3) (A)	4162(a) (1)	1388- 96	—	102, 752- 762
Medicare - Definitions - Partial Hospitalization	1861(ff) (3)	4162(a) (2)	1388- 96	—	102, 752- 762
Medicare - Definitions - Partial Hospitalization	1861(ff) (3) (B) New	4162(a) (3)	1388- 96	—	102, 752- 762
Medicare - Definitions - Screening Mammography	1861(jj) New	4156(a) (2)	1388- 88	84	94, 752- 763
Medicare - Definitions - Covered Osteoporosis Drug	1861(jj) New	4163(a) (2)	1388- 96	—	103, 763- 765
Medicare - Exclusions from Coverage	1862(a) (1) (A)	4163(d) (2) (A) (i)	1388- 100	—	106, 763- 765
Medicare - Exclusions from Coverage	1862(a) (1) (D)	4163(d) (2) (A) (ii)	1388- 100	—	106, 763- 765

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<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>104 Stat.</u>	<u>H. Rep. 101-881</u>	<u>H.C.Rep. 101-964</u>
Medicare - Exclusions from Coverage	1862(a) (1) (E)	4163(d) (2) (A) (iii)	1388- 100	—	106, 763- 765
Medicare - Exclusions from Coverage	1862(a) (1) (F) New	4163(d) (2) (A) (iv)	1388- 100	—	107, 763- 765
Medicare - Exclusions from Coverage	1862(a) (2)	4161(a) (3) (C) (i)	1388- 94	—	100, 752- 762
Medicare - Exclusions from Coverage	1862(a) (3)	4161(a) (3) (C) (ii)	1388- 94	—	100, 752- 762
Medicare - Exclusions from Coverage	1862(a) (7)	4153(b) (2) (B)	1388- 84	79- 82, 235- 237, 265- 269	90, 743- 749
Medicare - Exclusions from Coverage	1862(a) (7)	4163(d) (2) (B)	1388- 100	—	107, 763- 765
Medicare - Exclusions from Coverage	1862(a) (14)	4157(c) (1) (A)	1388- 89	—	95, 752- 762
Medicare - Exclusions from Coverage	1862(a) (14)	4157(c) (1) (B)	1388- 89	—	95, 752- 762
Medicare - Exclusions from Coverage (technical amendment)	1862(a) (15) Redesignated as 1862(a) (15) (A)	4107(b) (1)	1388- 62	234, 260- 262	67, 732- 739
Medicare - Exclusions from Coverage (technical amendment)	1862(a) (15)	4107(b) (2)	1388- 62	234, 260- 262	67, 732- 739
Medicare - Exclusions from Coverage	1862(a) (15) (B) New	4107(b) (3)	1388- 62	234, 260- 262	67, 732- 739

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<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>104 Stat.</u>	<u>H. Rep. 101-881</u>	<u>H.C.Rep. 101-964</u>
Medicare - Exclusions from Coverage	1862 (a)	4161 (a) (3) (C) (iii)	1388- 94	—	100, 752- 762
Medicare as Secondary Payer	1862 (b) (1) (B) (iii)	4203 (b)	1388- 107	87, 237- 238, 271- 272	114, 771- 774
Medicare as Secondary Payer	1862 (b) (1) (C) (i)	4203 (c) (1) (A)	1388- 107	87, 237- 238, 271- 272	115, 771- 774
Medicare as Secondary Payer	1862 (b) (1) (C)	4203 (c) (1) (B)	1388- 107	87, 237- 238, 271- 272	115, 771- 774
Medicare as Secondary Payer	1862 (b) (3) (C) New	4204 (g) (1)	1388- 112	87- 89	119- 120, 778- 783
Medicare as Secondary Payer	1862 (b) (5) (C) (iii)	4203 (a) (1)	1388- 107	87, 237- 238, 271- 272	114, 771- 774
Medicare - Consultation with State Agencies	1863	4163 (c) (1)	1388- 99	—	106, 763- 765
Medicare - Use of State Agencies to Determine Compliance	1864 (a)	4154 (d) (1)	1388- 85	82- 83, 237, 269- 270	91, 750- 751
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Subject	S.S. Act Section	P.L. Section	104 Stat.	H. Rep. 101-881	H.C.Rep. 101-964
Medicare - Use of State Agencies to Determine Compliance	1864(e) New	4027(g)	1388- 123	—	131, 810- 819
Medicare - Effect of Accreditation	1865(a)	4163(c) (3)	1388- 100	—	106, 763- 765
Medicare - Agreements with Providers of Services (technical amendment)	1866(a) (1) (F) (i)	4008(m) (3) (G) (i)	1388- 54	—	58, 711- 717
Medicare - Agreements with Providers of Services (technical amendment)	1866(a) (1) (F) (ii)	4008(m) (3) (G) (ii)	1388- 54	—	58, 711- 717
Medicare - Agreements with Providers of Services	1866(a) (1) (H)	4157(c) (2)	1388- 89	—	95, 752- 762
Medicare - Agreements with Providers of Services	1866(a) (1) (I) (i)	4008(b) (3) (B)	1388- 44	—	48, 715- 716
Medicare - Agreements with Providers of Services (technical amendment)	1866(a) (1) (O)	4206(a) (1) (A)	1388- 115	—	122, 774- 778
Medicare - Agreements with Providers of Services	1866(a) (1) (P)	4153(d) (1)	1388- 84	79- 82, 235- 237, 265- 269	90, 743- 749
Medicare - Agreements with Providers of Services	1866(a) (1) (P)	4206(d) (1) (B)	1388- 115	—	122, 774- 778
Medicare - Agreements with Providers of Services	1866(a) (1) (Q) New	4206(a) (1) (C)	1388- 115	—	122- 123, 774- 778

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<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>104 Stat.</u>	<u>H. Rep. 101-881</u>	<u>H.C.Rep. 101-964</u>
Medicare - Agreements with Providers of Services	1866(e)	4162(b) (2)	1388- 96	—	102- 103, 752- 762
Medicare - Agreements with Providers of Services	1866(f) New	4206(a) (2)	1388- 115	—	123, 774- 778
Medicare - Examination and Treatment for Emergency Medical Conditions and Women in Labor	1867(c) (2) (C)	4008(b) (3) (A) (iii)	1388- 44	—	47, 715- 716
Medicare - Examination and Treatment for Emergency Medical Conditions and Women in Labor	1867(d) (1) Stricken	4008(b) (3) (A) (i)	1388- 44	—	47, 715- 716
Medicare - Examination and Treatment for Emergency Medical Conditions and Women in Labor	1867(d) (2) (A)	4008(b) (1)	1388- 44	—	47, 715- 716
Medicare - Examination and Treatment for Emergency Medical Conditions and Women in Labor	1867(d) (2) (A)	4008(b) (2)	1388- 44	—	47, 715- 716
Medicare - Examination and Treatment for Emergency Medical Conditions and Women in Labor (technical amendment)	1867(d) (2) Redesignated as 1867(d) (1)	4008(b) (3) (A) (ii)	1388- 44	—	47, 715- 716
Medicare - Examination and Treatment for Emergency Medical Conditions and Women in Labor	1867(d) (2) (B)	4027(a) (2)	1388- 117	—	125, 810- 819
Medicare - Examination and Treatment for Emergency Medical Conditions and Women in Labor	1867(d) (2) (B)	4027(a) (3)	1388- 117	—	125, 810- 819

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Subject	S.S. Act Section	P.L. Section	104 Stat.	H. Rep. 101-881	H.C.Rep. 101-964
Medicare - Examination and Treatment for Emergency Medical Conditions and Women in Labor (technical amendment)	1867(d) (3) Redesignated as 1867(d) (2)	4008 (b) (3) (A) (ii)	1388- 44	—	47, 715- 716
Medicare - Examination and Treatment for Emergency Medical Conditions and Women in Labor	1867(d) (3) New	4027(a) (1) (A)	1388- 117	—	124- 125, 810- 819
Medicare - Examination and Treatment for Emergency Medical Conditions and Women in Labor	1867(i)	4027(k) (3)	1388- 124	—	132, 810- 819
Medicare - Practicing Physicians Advisory Council	1868 New	4112	1388- 64	76	69, 732- 739
Medicare - Payments to Health Maintenance Organizations and Competitive Medical Plans (technical amendment)	1876(a) (1) (E) Redesignated as 1876(a) (1) (E) (i)	4204 (e) (1) (A)	1388- 111	87- 89	118, 778- 783
Medicare - Payments to Health Maintenance Organizations and Competitive Medical Plans	1876(a) (1) (E) (ii) New	4204 (e) (1) (B)	1388- 111	87- 89	118, 778- 783
Medicare - Payments to Health Maintenance Organizations and Competitive Medical Plans	1876(a) (6)	4204 (c) (2)	1388- 110	87- 89	118, 778- 783
Medicare - Payments to Health Maintenance Organizations and Competitive Medical Plans (technical amendment)	1876(c) (2) (A) Redesignated as 1876(c) (2) (i)	4204 (c) (1) (A)	1388- 110	87- 89	117, 778- 783
Medicare - Payments to Health Maintenance Organizations and Competitive Medical Plans (technical amendment)	1876(c) (2) Redesignated as 1876(c) (2) (A)	4204 (c) (1) (B)	1388- 110	87- 89	117, 778- 783
Medicare - Payments to Health Maintenance Organizations and Competitive Medical Plans (technical amendment)	1876(c) (2) (B) Redesignated as 1876(c) (2) (ii)	4204 (c) (1) (A)	1388- 110	87- 89	117, 778- 783

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<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>104 Stat.</u>	<u>H. Rep. 101-881</u>	<u>H.C.Rep. 101-964</u>
Medicare - Payments to Health Maintenance Organizations and Competitive Medical Plans (technical amendment)	1876(c) (2) (i) Redesignated as 1876(c) (2) (A) (I)	4204 (c) (1) (A)	1388- 110	87- 89	117, 778- 783
Medicare - Payments to Health Maintenance Organizations and Competitive Medical Plans (technical amendment)	1876(c) (2) (ii) Redesignated as 1876(c) (2) (A) (II)	4204 (c) (1) (A)	1388- 110	87- 89	117, 778- 783
Medicare - Payments to Health Maintenance Organizations and Competitive Medical Plans	1876(c) (2) (B) New	4204 (c) (1) (C)	1388- 110	87- 89	117- 118, 778- 783
Medicare - Payments to Health Maintenance Organizations and Competitive Medical Plans	1876(c) (8) New	4206 (b) (1)	1388- 116	86	124, 774- 778
Medicare - Payments to Health Maintenance Organizations and Competitive Medical Plans	1876(i) (6) (A) (vi)	4204 (a) (2)	1388- 109	87- 89	116, 778- 783
Medicare - Payments to Health Maintenance Organizations and Competitive Medical Plans	1876(i) (8) New	4204 (a) (1)	1388- 108	87- 89	116, 778- 783
Medicare - Payments to Health Maintenance Organizations and Competitive Medical Plans	1876(j) (1) (A)	4204 (d) (1) (A) (i)	1388- 111	87- 89	118, 778- 783
Medicare - Payments to Health Maintenance Organizations and Competitive Medical Plans	1876(j) (1) (A)	4204 (d) (1) (A) (ii)	1388- 111	87- 89	118, 778- 783
Medicare - Payments to Health Maintenance Organizations and Competitive Medical Plans	1876(j) (1) (A)	4204 (d) (1) (A) (iii)	1388- 111	87- 89	118, 778- 783
Medicare - Payments to Health Maintenance Organizations and Competitive Medical Plans	1876(j) (2)	4204 (d) (1) (B) (i)	1388- 111	87- 89	118, 778- 783
Medicare - Payments to Health Maintenance Organizations and Competitive Medical Plans	1876(j) (2)	4204 (d) (1) (B) (ii)	1388- 111	87- 89	118, 778- 783

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<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>104 Stat.</u>	<u>H. Rep. 101-881</u>	<u>H.C.Rep. 101-964</u>
Medicare - Limitation on Certain Physician Referrals (technical amendment)	1877(b) (4) Redesignated as 1877(b) (5)	4027(e) (2)	1388- 122	—	129- 130, 810- 819
Medicare - Limitation on Certain Physician Referrals	1877(b) (4) New	4027(e) (2)	1388- 122	—	130, 810- 819
Medicare - Limitation on Certain Physician Referrals	1877(f) (2)	4027(e) (3) (A)	1388- 122	—	130, 810- 819
Medicare - Limitation on Certain Physician Referrals	1877(f)	4027(e) (3) (B)	1388- 122	—	130, 810- 819
Medicare - Limitation on Certain Physician Referrals	1877(f)	4027(e) (3) (C)	1388- 122	—	130, 810- 819
Medicare - Limitation on Certain Physician Referrals	1877(g) (5)	4027(k) (2)	1388- 122	—	135, 810- 819
Medicare - Limitation on Certain Physician Referrals	1877(h) (6) (A)	4027(e) (1) (A)	1388- 121	—	129, 810- 819
Medicare - Limitation on Certain Physician Referrals	1877(h) (6) (B)	4027(e) (1) (B)	1388- 121	—	129, 810- 819
Medicare - Limitation on Certain Physician Referrals (technical amendment)	1877(h) (6) Redesignated as 1877(h) (7)	4027(e) (1) (C)	1388- 121	—	129, 810- 819
Medicare - Limitation on Certain Physician Referrals	1877(h) (6) New	4027(e) (1) (C)	1388- 121	—	129, 810- 819
Medicare - Provider Reimbursement Review Board	1878(j) New	4161(a) (6)	1388- 94	—	100- 101, 752- 762

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<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>104 Stat.</u>	<u>H. Rep. 101-881</u>	<u>H.C.Rep. 101-964</u>
Medicare - Provider Reimbursement Review Board	1878(j)	4161(b) (4)	1388- 95	—	102, 752- 762
Medicare - Coverage for End Stage Renal Disease	1881(b) (1) (A)	4201(d) (2) (A) (B)	1388- 104	87, 237, 270- 271	111, 765- 771
Medicare - Coverage for End Stage Renal Disease	1881(b) (1) (B)	4201(d) (2) (A) (C)	1388- 104	87, 237, 270- 271	111, 765- 771
Medicare - Coverage for End Stage Renal Disease	1881(b) (1) (C) New	4201(d) (2) (A) (C)	1388- 104	87, 237, 270- 271	111, 765- 771
Medicare - Coverage for End Stage Renal Disease (technical amendment)	1881(b) (11) Redesignated as 1881(b) (11) (A)	4201(c) (1) (A)	1388- 103	87, 237, 270- 271	110- 111, 765- 771
Medicare - Coverage for End Stage Renal Disease	1881(b) (11) (B) New	4201(c) (1) (B)	1388- 103	87, 237, 270- 271	110- 111, 765- 771
Medicare - Coverage for End Stage Renal Disease	1881(b) (11) (C) New	4201(d) (3)	1388- 104	87, 237, 270- 271	111, 765- 771
Medicare - Certification of Medicare Supplemental Health Insurance Policies	1882	4353(a) (1)	1388- 129	91- 95	137, 783- 806
Medicare - Certification of Medicare Supplemental Health Insurance Policies (technical amendment)	1882(a) Redesignated as 1882(a) (1)	4353(a) (2) (A)	1388- 129	91- 95	137, 783- 806
Medicare - Certification of Medicare Supplemental Health Insurance Policies	1882(a) (2) New	4353(a) (2) (B)	1388- 129	91- 95	137- 138, 783- 806

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<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>104 Stat.</u>	<u>H. Rep. 101-881</u>	<u>H.C.Rep. 101-964</u>
Medicare - Certification of Medicare Supplemental Health Insurance Policies	1882(a)	4027(k) (1)	1388- 124	—	132, 810- 819
Medicare - Certification of Medicare Supplemental Health Insurance Policies	1882(b) (1)	4027(k) (1)	1388- 124	—	132, 810- 819
Medicare - Certification of Medicare Supplemental Health Insurance Policies	1882(b) (1)	4353(b) (1)	1388- 130	91- 95	138, 783- 806
Medicare - Certification of Medicare Supplemental Health Insurance Policies	1882(b) (1)	4353(b) (2)	1388- 130	91- 95	138, 783- 806
Medicare - Certification of Medicare Supplemental Health Insurance Policies	1882(b) (1) (A)	4353(b) (3)	1388- 130	91- 95	138, 783- 806
Medicare - Certification of Medicare Supplemental Health Insurance Policies	1882(b) (1) (A)	4358(b) (2) (A)	1388- 137	91- 95	145, 783- 806
Medicare - Certification of Medicare Supplemental Health Insurance Policies	1882(b) (1) (B)	4351(a) (1)	1388- 125	91- 95	133, 783- 806
Medicare - Certification of Medicare Supplemental Health Insurance Policies	1882(b) (1) (C)	4355(b)	1388- 134	91- 95	142- 143, 783- 806
Medicare - Certification of Medicare Supplemental Health Insurance Policies	1882(b) (1) (D)	4353(b) (3)	1388- 130	91- 95	138, 783- 806
Medicare - Certification of Medicare Supplemental Health Insurance Policies (technical amendment)	1882(b) (1) (D)	4353(c) (1)	1388- 130	91- 95	138, 783- 806
Medicare - Certification of Medicare Supplemental Health Insurance Policies (technical amendment)	1882(b) (1) (E)	4353(c) (2)	1388- 130	91- 95	138, 783- 806

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<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>104 Stat.</u>	<u>H. Rep. 101-881</u>	<u>H.C.Rep. 101-964</u>
Medicare - Certification of Medicare Supplemental Health Insurance Policies (technical amendment)	1882(b) (1) (E)	4355(c) (1)	1388- 134	91- 95	143, 783- 806
Medicare - Certification of Medicare Supplemental Health Insurance Policies	1882(b) (1) (F) New	4353(c) (3)	1388- 130	91- 95	138, 783- 806
Medicare - Certification of Medicare Supplemental Health Insurance Policies	1882(b) (1) (F)	4355(c) (2) (ii)	1388- 134	91- 95	143, 783- 806
Medicare - Certification of Medicare Supplemental Health Insurance Policies (technical amendment)	1882(b) (1) (F)	4358(b) (2) (B)	1388- 137	91- 95	145, 783- 806
Medicare - Certification of Medicare Supplemental Health Insurance Policies	1882(b) (1) (G) New	4355(c) (3)	1388- 134	91- 95	143, 783- 806
Medicare - Certification of Medicare Supplemental Health Insurance Policies (technical amendment)	1882(b) (1) (G)	4358(b) (2) (C)	1388- 137	91- 95	145, 783- 806
Medicare - Certification of Medicare Supplemental Health Insurance Policies	1882(b) (1) (H) New	4358(b) (2) (D)	1388- 137	91- 95	145, 783- 806
Medicare - Certification of Medicare Supplemental Health Insurance Policies	1882(b) (1)	4353(c) (5)	1388- 130	91- 95	138- 139, 783- 806
Medicare - Certification of Medicare Supplemental Health Insurance Policies	1882(b) (2)	4353(b) (4)	1388- 130	91- 95	138, 783- 806
Medicare - Certification of Medicare Supplemental Health Insurance Policies	1882(c)	4357(a) (1)	1388- 135	91- 95	143, 783- 806
Medicare - Certification of Medicare Supplemental Health Insurance Policies	1882(c) (1)	4358(b) (1)	1388- 136	91- 95	145, 783- 806

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<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>104 Stat.</u>	<u>H. Rep. 101-881</u>	<u>H.C.Rep. 101-964</u>
Medicare - Certification of Medicare Supplemental Health Insurance Policies	1882(c) (2)	4355(a) (1)	1388- 133	91- 95	141, 783- 806
Medicare - Certification of Medicare Supplemental Health Insurance Policies (technical amendment)	1882(c) (3)	4351(a) (2) (A)	1388- 125	91- 95	133, 783- 806
Medicare - Certification of Medicare Supplemental Health Insurance Policies	1882(c) (4)	4355(a) (2)	1388- 133	91- 95	141, 783- 806
Medicare - Certification of Medicare Supplemental Health Insurance Policies (technical amendment)	1882(c) (4)	4351(a) (2) (B)	1388- 125	91- 95	133, 783- 806
Medicare - Certification of Medicare Supplemental Health Insurance Policies	1882(c) (5) New	4351(a) (2) (C)	1388- 125	91- 95	134, 783- 806
Medicare - Certification of Medicare Supplemental Health Insurance Policies	1882(d) (3) (A)	4354(a) (1) (A)	1388- 130	91- 95	139, 783- 806
Medicare - Certification of Medicare Supplemental Health Insurance Policies	1882(d) (3) (A)	4354(a) (1) (B)	1388- 130	91- 95	139, 783- 806
Medicare - Certification of Medicare Supplemental Health Insurance Policies	1882(d) (3) (A)	4354(a) (1) (C)	1388- 130	91- 95	139, 783- 806
Medicare - Certification of Medicare Supplemental Health Insurance Policies	1882(d) (3) (A)	4354(a) (1) (D)	1388- 130	91- 95	139, 783- 806
Medicare - Certification of Medicare Supplemental Health Insurance Policies	1882(d) (3) (A)	4354(a) (1) (E)	1388- 130	91- 95	139, 783- 806
Medicare - Certification of Medicare Supplemental Health Insurance Policies	1882(d) (3) (A)	4354(a) (1) (F)	1388- 130	91- 95	139, 783- 806

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<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>104 Stat.</u>	<u>H. Rep. 101-881</u>	<u>H.C.Rep. 101-964</u>
Medicare - Certification of Medicare Supplemental Health Insurance Policies	1882(d) (3) (B)	4354(a) (2)	1388- 130	91- 95	139, 783- 806
Medicare - Certification of Medicare Supplemental Health Insurance Policies	1882(d) (4) (B)	4353(d) (1)	1388- 130	91- 95	139, 783- 806
Medicare - Certification of Medicare Supplemental Health Insurance Policies	1882(g) (1)	4356(a)	1388- 134	91- 95	143, 783- 806
Medicare - Certification of Medicare Supplemental Health Insurance Policies	1882(o) New	4351(a) (3)	1388- 126	91- 95	134, 783- 806
Medicare - Certification of Medicare Supplemental Health Insurance Policies	1882(p) New	4351(a) (3)	1388- 126	91- 95	134, 783- 806
Medicare - Certification of Medicare Supplemental Health Insurance Policies	1882(q)	4352	1388- 129	91- 95	137, 783- 806
Medicare - Certification of Medicare Supplemental Health Insurance Policies	1882(q) (5) New	4354(b)	1388- 132	91- 95	140- 141, 783- 806
Medicare - Certification of Medicare Supplemental Health Insurance Policies	1882(r) New	4355(a) (3)	1388- 133	91- 95	141- 142, 783- 806
Medicare - Certification of Medicare Supplemental Health Insurance Policies	1882(s) New	4357(a) (2)	1388- 135	91- 95	143- 144, 783- 806
Medicare - Certification of Medicare Supplemental Health Insurance Policies	1882(t) New	4358(a) (1)	1388- 135	91- 95	144- 145, 783- 806
Medicare -Hospital Providers of Extended Care Services	1883(a) (2) (B) (ii) (II)	4008(j)	1388- 51	—	55, 715- 716

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<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>104 Stat.</u>	<u>H. Rep. 101-881</u>	<u>H.C.Rep. 101-964</u>
Medicare - Payment to Hospitals for Inpatient Hospital Services	1886(a) (4)	4003(a)	1388- 38	231, 258	42, 700- 701
Medicare - Payment to Hospitals for Inpatient Hospital Services	1886(b) (1) (B)	4005(a)	1388- 40	231- 232, 252- 254	43, 701- 704
Medicare - Payment to Hospitals for Inpatient Hospital Services (technical amendment)	1886(b) (3) (B) (i) (V)	4002(a) (1) (A)	1388- 31	229- 231, 246- 250	34, 691- 692, 694, 697- 698
Medicare - Payment to Hospitals for Inpatient Hospital Services	1886(b) (3) (B) (i) (VI)	4002(a) (1) (B) (i)	1388- 32	229- 231, 246- 250	34, 691- 692, 694, 697- 698
Medicare - Payment to Hospitals for Inpatient Hospital Services (technical amendment)	1886(b) (3) (B) (i) (VI) Redesignated as 1886(b) (3) (B) (i) (IX)	4002(a) (1) (B) (ii)	1388- 32	229- 231, 246- 250	34, 691- 692, 694, 697- 698
Medicare - Payment to Hospitals for Inpatient Hospital Services	1886(b) (3) (B) (i) (VI) New	4002(a) (1) (C)	1388- 32	229- 231, 246- 250	34, 691- 692, 694, 697- 698
Medicare - Payment to Hospitals for Inpatient Hospital Services	1886(b) (3) (B) (i) (VI)	4002(c) (1) (A)	1388- 33	229- 231, 246- 250	36, 692, 694, 697- 699

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Subject	S.S. Act Section	P.L. Section	104 Stat.	H. Rep. 101-881	H.C.Rep. 101-964
Medicare - Payment to Hospitals for Inpatient Hospital Services	1886(b) (3) (B) (i) (VII) New	4002(a) (1) (C)	1388- 32	229- 231, 246- 250	34, 691- 692, 694, 697- 698
Medicare - Payment to Hospitals for Inpatient Hospital Services	1886(b) (3) (B) (i) (VII)	4002(c) (1) (B)	1388- 33	229- 231, 246- 250	36, 692, 694, 697- 699
Medicare - Payment to Hospitals for Inpatient Hospital Services	1886(b) (3) (B) (i) (VIII) New	4002(a) (1) (C)	1388- 32	229- 231, 246- 250	35, 691- 692, 694, 697- 698
Medicare - Payment to Hospitals for Inpatient Hospital Services	1886(b) (3) (B) (i) (VIII)	4002(c) (1) (C)	1388- 33	229- 231, 246- 250	36, 692, 694, 697- 699
Medicare - Payment to Hospitals for Inpatient Hospital Services	1886(b) (3) (B) (i) (IX)	4002(c) (1) (D) (i)	1388- 33	229- 231, 246- 250	36, 692, 694, 697- 699
Medicare - Payment to Hospitals for Inpatient Hospital Services (technical amendment)	1886(b) (3) (B) (i) (IX) Redesignated as 1886(b) (3) (B) (i) (XI)	4002(c) (1) (D) (ii)	1388- 33	229- 231, 246- 250	36, 692, 694, 697- 699
Medicare - Payment to Hospitals for Inpatient Hospital Services	1886(b) (3) (B) (i) (IX)	4002(c) (1) (E)	1388- 33	229- 231, 246- 250	36, 692, 694, 697- 699

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Subject	S.S. Act Section	P.L. Section	104 Stat.	H. Rep. 101-881	H.C.Rep. 101-964
Medicare - Payment to Hospitals for Inpatient Hospital Services	1886(b) (3) (B) (i) (X) New	4002(c) (1) (E)	1388- 33	229- 231, 246- 250	37, 692, 694, 697- 699
Medicare - Payment to Hospitals for Inpatient Hospital Services (conforming amendment)	1886(b) (3) (B) (ii)	4002(c) (2) (A) (i)	1388- 34	229- 231, 246- 250	37, 692, 694, 697- 699
Medicare - Payment to Hospitals for Inpatient Hospital Services (conforming amendment)	1886(b) (3) (C) (ii)	4002(c) (2) (A) (ii)	1388- 34	229- 231, 246- 250	37, 692, 694, 697- 699
Medicare - Payment to Hospitals for Inpatient Hospital Services	1886(b) (3) (D) (ii)	4002(c) (2) (A) (ii)	1388- 34	229- 231, 246- 250	37, 692, 694, 697- 699
Medicare - Payment to Hospitals for Inpatient Hospital Services	1886(b) (4) (A)	4005(c) (1) (B)	1388- 42	231- 232, 252- 254	45, 701- 704
Medicare - Payment to Hospitals for Inpatient Hospital Services (technical amendment)	1886(b) (4) (B) Redesignated as 1886(b) (4) (C)	4005(c) (2) (A)	1388- 42	231- 232, 252- 254	45, 701- 704
Medicare - Payment to Hospitals for Inpatient Hospital Services	1886(b) (4) (B) New	4005(c) (2) (B)	1388- 42	231- 232, 252- 254	45- 46, 701- 704
Medicare - Payment to Hospitals for Inpatient Hospital Services	1886(c) (4)	4008(f) (1)	1388- 45	—	49, 705, 713- 714

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<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>104 Stat.</u>	<u>H. Rep. 101-881</u>	<u>H.C.Rep. 101-964</u>
Medicare - Payment to Hospitals for Inpatient Hospital Services (conforming amendment)	1886(d) (1) (A) (iii)	4002(c) (2) (B) (i)	1388- 34	229- 231, 246- 250	37, 692, 694, 697- 699
Medicare - Payment to Hospitals for Inpatient Hospital Services	1886(d) (1) (A) (iii)	4002(e) (1)	1388- 35	229- 231, 246- 250	38, 693, 695, 697- 699
Medicare - Payment to Hospitals for Inpatient Hospital Services	1886(d) (2) (C) (iv)	4002(b) (3) (A)	1388- 32	229- 231, 246- 250	35, 692, 694- 695, 697- 699
Medicare - Payment to Hospitals for Inpatient Hospital Services	1886(d) (2) (C) (iv)	4002(b) (4) (A)	1388- 33	229- 231, 246- 250	36, 692, 694- 695, 697- 699
Medicare - Payment to Hospitals for Inpatient Hospital Services	1886(d) (2) (C) (iv)	4002(b) (4) (B)	1388- 33	229- 231, 246- 250	36, 692, 694- 695, 697- 699
Medicare - Payment to Hospitals for Inpatient Hospital Services	1886(d) (3) (A) (ii)	4002(c) (2) (B) (ii) (I)	1388- 34	229- 231, 246- 250	37, 692, 694, 697- 699
Medicare - Payment to Hospitals for Inpatient Hospital Services (technical amendment)	1886(d) (3) (A) (iii) Redesignated as 1886(d) (3) (A) (v)	4002(c) (2) (B) (ii)	1388- 34	229- 231, 246- 250	37, 692, 694, 697- 699

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Subject	S.S. Act Section	P.L. Section	104 Stat.	H. Rep. 101-881	H.C.Rep. 101-964
Medicare - Payment to Hospitals for Inpatient Hospital Services	1886(d) (3) (A) (iii) New	4002(c) (2) (B) (ii) (III)	1388- 34	229- 231, 246- 250	37, 692, 694, 697- 699
Medicare - Payment to Hospitals for Inpatient Hospital Services	1886(d) (3) (A) (iv) New	4002(c) (2) (B) (ii) (III)	1388- 34	229- 231, 246- 250	37, 692, 694, 697- 699
Medicare - Payment to Hospitals for Inpatient Hospital Services	1886(d) (3) (B)	4002(c) (2) (B) (iii)	1388- 34	229- 231, 246- 250	37, 692, 694, 697- 699
Medicare - Payment to Hospitals for Inpatient Hospital Services	1886(d) (3) (C) (ii)	4002(b) (3) (B)	1388- 33	229- 231, 246- 250	35, 692, 694- 695, 697- 699
Medicare - Payment to Hospitals for Inpatient Hospital Services	1886(d) (3) (D) (i)	4002(c) (2) (B) (iv) (I)	1388- 34	229- 231, 246- 250	37, 692, 694- 695, 697- 699
Medicare - Payment to Hospitals for Inpatient Hospital Services	1886(d) (3) (D) (i) (I)	4002(c) (2) (B) (iv) (II)	1388- 34	229- 231, 246- 250	37, 692, 694, 697- 699
Medicare - Payment to Hospitals for Inpatient Hospital Services	1886(d) (3) (D) (ii)	4002(c) (2) (B) (v)	1388- 34	229- 231, 246- 250	37, 692, 694, 697- 699

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Subject	S.S. Act Section	P.L. Section	104 Stat.	H. Rep. 101-881	H.C.Rep. 101-964
Medicare - Payment to Hospitals for Inpatient Hospital Services	1886(d) (4) (D) Stricken	4002(g) (2) (A)	1388- 36	229- 231, 246- 250	39, 693- 700
Medicare - Payment to Hospitals for Inpatient Hospital Services	1886(d) (5) (B) (ii)	4002(b) (3) (B)	1388- 32	229- 231, 246- 250	35, 692, 694- 695, 697- 699
Medicare - Payment to Hospitals for Inpatient Hospital Services	1886(d) (5) (D) (iii)	4008(m) (2) (A)	1388- 53	--	57, 711- 717
Medicare - Payment to Hospitals for Inpatient Hospital Services	1886(d) (5) (F) (i)	4002(b) (3) (A)	1388- 32	229- 231, 246- 250	35, 692, 694- 695, 697- 699
Medicare - Payment to Hospitals for Inpatient Hospital Services	1886(d) (5) (F) (iii)	4002(b) (2)	1388- 32	229- 231, 246- 250	35, 692, 694- 695, 697- 699
Medicare - Payment to Hospitals for Inpatient Hospital Services	1886(d) (5) (F) (vii) (I)	4002(b) (1) (A)	1388- 32	229- 231, 246- 250	35, 692, 694- 695, 697- 699
Medicare - Payment to Hospitals for Inpatient Hospital Services	1886(d) (5) (F) (vii) (II)	4002(b) (1) (B)	1388- 32	229- 231, 246- 250	35, 692, 694- 695, 697- 699

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Subject	S.S. Act Section	P.L. Section	104 Stat.	H. Rep. 101-881	H.C.Rep. 101-964
Medicare - Payment to Hospitals for Inpatient Hospital Services	1886(d) (8) (C) (i)	4002(h) (1) (A) (i)	1388- 37	229- 231, 246- 250	41, 691- 700
Medicare - Payment to Hospitals for Inpatient Hospital Services	1886(d) (8) (C) (i) (II)	4002(h) (1) (A) (ii)	1388- 37	229- 231, 246- 250	41, 691- 700
Medicare - Payment to Hospitals for Inpatient Hospital Services	1886(d) (8) (C) (ii) Stricken	4002(h) (1) (A) (iii)	1388- 37	229- 231, 246- 250	41, 691- 700
Medicare - Payment to Hospitals for Inpatient Hospital Services (technical amendment)	1886(d) (8) (C) (i) (iii) Redesignated as 1886(d) (8) (C) (ii)	4002(h) (1) (A) (iv)	1388- 37	229- 231, 246- 250	41, 691- 700
Medicare - Payment to Hospitals for Inpatient Hospital Services (technical amendment)	1886(d) (8) (C) (iv) Redesignated as 1886(d) (8) (C) (iii)	4002(h) (1) (A) (iv)	1388- 37	229- 231, 246- 250	41, 691- 700
Medicare - Payment to Hospitals for Inpatient Hospital Services	1886(d) (8) (D)	4002(c) (2) (B) (vi) (I)	1388- 35	229- 231, 246- 250	37- 38, 692, 694, 697- 699
Medicare - Payment to Hospitals for Inpatient Hospital Services	1886(d) (8) (D)	4002(c) (2) (B) (vi) (II)	1388- 35	229- 231, 246- 250	37- 38, 692, 694, 697- 699
Medicare - Payment to Hospitals for Inpatient Hospital Services (technical amendment)	1886(d) (10) (A)	4002(h) (2) (B) (i)	1388- 38	229- 231, 246- 250	41, 691- 700

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Subject	S.S. Act Section	P.L. Section	104 Stat.	H. Rep. 101-881	H.C.Rep. 101-964
Medicare - Payment to Hospitals for Inpatient Hospital Services (technical amendment)	1886(d) (10) (B) (i)	4002(h) (2) (B) (ii) (I)	1388- 38	229- 231, 246- 250	41, 691- 700
Medicare - Payment to Hospitals for Inpatient Hospital Services (technical amendment)	1886(d) (10) (B) (i)	4002(h) (2) (B) (ii) (II)	1388- 38	229- 231, 246- 250	41, 691- 700
Medicare - Payment to Hospitals for Inpatient Hospital Services (technical amendment)	1886(d) (10) (B) (ii)	4002(h) (2) (B) (iii)	1388- 38	229- 231, 246- 250	41, 691- 700
Medicare - Payment to Hospitals for Inpatient Hospital Services (technical amendment)	1886(d) (10) (B) (iii) (II)	4002(h) (2) (B) (iv) (I)	1388- 38	229- 231, 246- 250	41, 691- 700
Medicare - Payment to Hospitals for Inpatient Hospital Services (technical amendment)	1886(d) (10) (C) (iii) (II)	4002(h) (2) (B) (iv) (II)	1388- 38	229- 231, 246- 250	42, 691- 700
Medicare - Payment to Hospitals for Inpatient Hospital Services (technical amendment)	1886(e) (2) Redesignated as 1886(e) (2) (A)	4002(g) (1) (A)	1388- 36	229- 231, 246- 250	39, 693- 700
Medicare - Payment to Hospitals for Inpatient Hospital Services	1886(e) (2) (A)	4002(g) (2) (B)	1388- 36	229- 231, 246- 250	39, 693- 700
Medicare - Payment to Hospitals for Inpatient Hospital Services	1886(e) (2) (B) New	4002(g) (1) (B)	1388- 36	229- 231, 246- 250	39, 693- 700
Medicare - Payment to Hospitals for Inpatient Hospital Services	1886(e) (2) (C) New	4002(g) (1) (B)	1388- 36	229- 231, 246- 250	39, 693- 700

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<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>104 Stat.</u>	<u>H. Rep. 101-881</u>	<u>H.C.Rep. 101-964</u>
Medicare - Payment to Hospitals for Inpatient Hospital Services	1886(e) (3) (A)	4002(g) (2) (C) (i)	1388- 36	229- 231, 246- 250	40, 693- 700
Medicare - Payment to Hospitals for Inpatient Hospital Services	1886(e) (3) (A)	4002(g) (2) (C) (ii)	1388- 36	229- 231, 246- 250	40, 693- 700
Medicare - Payment to Hospitals for Inpatient Hospital Services (technical amendment)	1886(e) (4) Redesignated as 1886(e) (4) (A)	4002(g) (2) (D) (i)	1388- 36	229- 231, 246- 250	40, 693- 700
Medicare - Payment to Hospitals for Inpatient Hospital Services	1886(e) (4) (B) New	4002(g) (2) (D) (ii)	1388- 36	229- 231, 246- 250	40, 693- 700
Medicare - Payment to Hospitals for Inpatient Hospital Services	1886(e) (5)	4002(g) (2) (E) (i)	1388- 36	229- 231, 246- 250	40, 693- 700
Medicare - Payment to Hospitals for Inpatient Hospital Services	1886(e) (5)	4002(g) (2) (E) (i)	1388- 36	229- 231, 246- 250	40, 693- 700
Medicare - Payment to Hospitals for Inpatient Hospital Services	1886(e) (6) (G) (i) Stricken	4002(g) (2) (F) (i)	1388- 36	229- 231, 246- 250	40, 693- 700
Medicare - Payment to Hospitals for Inpatient Hospital Services (technical amendment)	1886(e) (6) (G) (ii) Redesignated as 1886(e) (6) (G) (i)	4002(g) (2) (F) (ii)	1388- 36	229- 231, 246- 250	40, 693- 700
Medicare - Payment to Hospitals for Inpatient Hospital Services (technical amendment)	1886(e) (6) (G) (iii) Redesignated as 1886(e) (6) (G) (ii)	4002(g) (2) (F) (ii)	1388- 36	229- 231, 246- 250	40, 693- 700

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Subject	S.S. Act Section	P.L. Section	104 Stat.	H. Rep. 101-881	H.C.Rep. 101-964
Medicare - Payment to Hospitals for Inpatient Hospital Services	1886(g) (1) (A)	4001(b)	1388- 31	229, 245- 246	34, 690- 691
Medicare - Payment to Hospitals for Inpatient Hospital Services	1886(g) (3) (A) (v)	4001(a)	1388- 31	229, 245- 246	34, 690- 691
Medicare - Payment to Hospitals for Inpatient Hospital Services	1886(g) (3) (B)	4001(c)	1388- 31	229, 245- 246	34, 690- 691
Medicare - Payment to Skilled Nursing Facilities for Routine Service Costs	1888(a)	4008(e) (2)	1388- 45	—	49, 706, 708- 709, 711
Medicare - Payment to Skilled Nursing Facilities for Routine Service Costs	1888(d) (1)	4008(h) (2) (A) (ii)	1388- 48	—	52, 706- 714
Medicare and Medigap Information by Telephone	1889 New	4361(a)	1388- 141	91- 95	150, 783- 806
Medicare - Home Health Agencies	1891(a) (3) (D) (iii)	4027(i) (1)	1388- 123	—	132, 810- 819
Medicare - Home Health Agencies	1891(a) (6) New	4206(d) (2)	1388- 116	—	124, 774- 778
Medicaid - State Plans for Medical Assistance (technical amendment)	1902(a) (10) (A) (i) (V)	4601(a) (1) (A) (i)	1388- 166	102- 103	176, 837- 841
Medicaid - State Plans for Medical Assistance (technical amendment)	1902(a) (10) (A) (i) (VI)	4601(a) (1) (A) (ii)	1388- 166	102- 103	176, 837- 841
Medicaid - State Plans for Medical Assistance	1902(a) (10) (A) (i) (VII) New	4601(a) (1) (A) (iii)	1388- 166	102- 103	176, 837- 841

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Subject	S.S. Act Section	P.L. Section	104 Stat.	H. Rep. 101-881	H.C.Rep. 101-964
Medicaid - State Plans for Medical Assistance	1902(a) (10) (A) (ii) (IX)	4601(a) (1) (B)	1388- 166	102- 103	176, 837- 841
Medicaid - State Plans for Medical Assistance	1902(a) (10) (C) (iv)	4711(d) (2)	1388- 187	—	198, 855- 863
Medicaid - State Plans for Medical Assistance	1902(a) (10) (C) (iv)	4755(c) (1) (A)	1388- 210	—	223, 894- 899
Medicaid - State Plans for Medical Assistance (technical amendment)	1902(a) (10) (D)	4713(a) (1) (A)	1388- 190	—	202, 871- 877
Medicaid - State Plans for Medical Assistance (technical amendment)	1902(a) (10) (E) (i)	4501(b) (1)	1388- 164	101- 102	175, 835- 837
Medicaid - State Plans for Medical Assistance (technical amendment)	1902(a) (10) (E) (ii)	4501(b) (2)	1388- 164	101- 102	175, 835- 837
Medicaid - State Plans for Medical Assistance	1902(a) (10) (E) (iii) New	4501(b) (3)	1388- 164	101- 102	175, 835- 837
Medicaid - State Plans for Medical Assistance (technical amendment)	1902(a) (10) (E)	4713(a) (1) (B)	1388- 190	—	202, 871- 877
Medicaid - State Plans for Medical Assistance (technical amendment)	1902(a) (10) (IX)	4402(d) (1) (A)	1388- 163	99- 101	173, 833- 834
Medicaid - State Plans for Medical Assistance (technical amendment)	1902(a) (10) (X)	4402(d) (1) (B)	1388- 163	99- 101	173, 833- 834
Medicaid - State Plans for Medical Assistance	1902(a) (10) (XI) New	4402(d) (1) (C)	1388- 163	99- 101	173, 833- 834
Medicaid - State Plans for Medical Assistance	1902(a) (10) (F) New	4713(a) (1) (C)	1388- 190	—	202, 871- 877

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Subject	S.S. Act Section	P.L. Section	104 Stat.	H. Rep. 101-881	H.C.Rep. 101-964
Medicaid - State Plans for Medical Assistance	1902(a) (10)	4713(a) (1) (D)	1388- 190	—	202, 871- 877
Medicaid - State Plans for Medical Assistance	1902(a) (13) (A)	4801(e) (1) (A)	1388- 215	108- 127	228, 841- 855
Medicaid - State Plans for Medical Assistance (technical amendment)	1902(a) (13) (D)	4711(c) (1) (A) (i)	1388- 186	—	198, 855- 863
Medicaid - State Plans for Medical Assistance	1902(a) (13) (E)	4704(a) (2)	1388- 171	—	182, 866- 871
Medicaid - State Plans for Medical Assistance	1902(a) (13) (E)	4704(a) (1)	1388- 171	—	182, 866- 871
Medicaid - State Plans for Medical Assistance (technical amendment)	1902(a) (13) (E)	4711(c) (1) (A) (ii)	1388- 186	—	198, 855- 863
Medicaid - State Plans for Medical Assistance	1902(a) (13) (F) New	4711(c) (1) (A) (iii)	1388- 186	—	198, 855- 863
Medicaid - State Plans for Medical Assistance	1902(a) (17)	4723(b)	1388- 194	—	206, 871- 877
Medicaid - State Plans for Medical Assistance (technical amendment)	1902(a) (25) (E)	4402(a) (1) (A)	1388- 161	99- 101	171, 833- 834
Medicaid - State Plans for Medical Assistance (technical amendment)	1902(a) (25) (F)	4402(a) (1) (B)	1388- 161	99- 101	171, 833- 834
Medicaid - State Plans for Medical Assistance	1902(a) (25) (G) New	4402(a) (1) (C)	1388- 161	99- 101	171, 833- 834
Medicaid - State Plans for Medical Assistance	1902(a) (29) Repealed	4801(e) (11) (A)	1388- 217	99- 101	230, 841- 855

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<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>104 Stat.</u>	<u>H. Rep. 101-881</u>	<u>H.C.Rep. 101-964</u>
Medicaid - State Plans for Medical Assistance	1902(a) (32) (A)	4708(a) (1)	1388- 173	—	184, 866- 871
Medicaid - State Plans for Medical Assistance	1902(a) (32) (B)	4708(a) (2)	1388- 173	—	184, 866- 871
Medicaid - State Plans for Medical Assistance	1902(a) (32) (C) New	4708(a) (3)	1388- 173	—	184, 866- 871
Medicaid - State Plans for Medical Assistance	1902(a) (41)	4754(a)	1388- 208	—	221, 894- 899
Medicaid - State Plans for Medical Assistance (technical amendment)	1902(a) (52)	4401(a) (2) (A)	1388- 143	95- 98	152, 821- 833
Medicaid - State Plans for Medical Assistance (technical amendment)	1902(a) (53)	4401(a) (2) (B)	1388- 143	95- 98	152, 821- 833
Medicaid - State Plans for Medical Assistance	1902(a) (53)	4602(a) (1)	1388- 167	—	178, 837- 841
Medicaid - State Plans for Medical Assistance (technical amendment)	1902(a) (53)	4604(b) (1)	1388- 169	—	179, 837- 841
Medicaid - State Plans for Medical Assistance	1902(a) (54) New	4401(a) (2) (C)	1388- 143	95- 98	152, 821- 833
Medicaid - State Plans for Medical Assistance	1902(a) (54)	4602(a) (2)	1388- 167	—	178, 837- 841
Medicaid - State Plans for Medical Assistance (technical amendment)	1902(a) (54)	4604(b) (2)	1388- 169	—	179, 837- 841
Medicaid - State Plans for Medical Assistance	1902(a) (55) New	4602(a) (3)	1388- 167	—	178, 837- 841

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Subject	S.S. Act Section	P.L. Section	104 Stat.	H. Rep. 101-881	H.C.Rep. 101-964
Medicaid - State Plans for Medical Assistance	1902(a) (55) New	4604(b) (3)	1388- 169	—	179, 837- 841
Medicaid - State Plans for Medical Assistance (technical amendment)	1902(a) (55)	4751(a) (1) (A)	1388- 204	137- 139	216, 894- 899
Medicaid - State Plans for Medical Assistance (technical amendment)	1902(a) (56)	4751(a) (1) (B)	1388- 204	137- 139	216, 894- 899
Medicaid - State Plans for Medical Assistance (technical amendment)	1902(a) (56)	4752(c) (1) (A)	1388- 206	—	219, 894- 899
Medicaid - State Plans for Medical Assistance	1902(a) (57) New	4751(a) (1) (C)	1388- 204	137- 139	216, 894- 899
Medicaid - State Plans for Medical Assistance (technical amendment)	1902(a) (57)	4752(c) (1) (B)	1388- 206	—	219, 894- 899
Medicaid - State Plans for Medical Assistance	1902(a) (58) New	4751(a) (1) (C)	1388- 204	137- 139	216, 894- 899
Medicaid - State Plans for Medical Assistance	1902(a) (58) New	4752(c) (1) (C)	1388- 206	—	219, 894- 899
Medicaid - State Plans for Medical Assistance	1902(e) (2) (A)	4732(b) (1)	1388- 195	—	207, 877- 881
Medicaid - State Plans for Medical Assistance	1902(e) (4)	4603(a) (1)	1388- 168	103- 104	178, 837- 841
Medicaid - State Plans for Medical Assistance	1902(e) (6)	4603(a) (2) (A)	1388- 168	103- 104	178, 837- 841
Medicaid - State Plans for Medical Assistance	1902(e) (6)	4603(a) (2) (B)	1388- 168	103- 104	178, 837- 841

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Subject	S.S. Act Section	P.L. Section	104 Stat.	H. Rep. 101-881	H.C.Rep. 101-964
Medicaid - State Plans for Medical Assistance	1902(e) (6) New	4603(a) (2) (C)	1388- 168	103- 104	178, 837- 841
Medicaid - State Plans for Medical Assistance	1902(e) (11) New	4402 (c)	1388- 163	99- 101	173, 833- 834
Medicaid - State Plans for Medical Assistance	1902(h)	4711(c) (1) (B)	1388- 186	---	198, 855- 863
Medicaid - State Plans for Medical Assistance	1902(j)	4711(d) (1)	1388- 187	---	198, 855- 863
Medicaid - State Plans for Medical Assistance	1902(j)	4755(c) (1) (B)	1388- 210	---	223, 894- 899
Medicaid - State Plans for Medical Assistance	1902(l) (1) (C)	4601(a) (1) (C) (i)	1388- 166	102- 103	176, 837- 841
Medicaid - State Plans for Medical Assistance	1902(l) (1) (D)	4601(a) (1) (C) (ii)	1388- 166	102- 103	176, 837- 841
Medicaid - State Plans for Medical Assistance	1902(l) (2) (C)	4601(a) (1) (C) (iii)	1388- 166	102- 103	176- 177, 837- 841
Medicaid - State Plans for Medical Assistance	1902(l) (3)	4601(a) (1) (C) (iv)	1388- 166	102- 103	177, 837- 841
Medicaid - State Plans for Medical Assistance	1902(l) (4) (A)	4601(a) (1) (C) (v)	1388- 166	102- 103	177, 837- 841
Medicaid - State Plans for Medical Assistance	1902(l) (4) (B)	4601(a) (1) (C) (vi)	1388- 166	102- 103	177, 837- 841

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<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>104 Stat.</u>	<u>H. Rep. 101-881</u>	<u>H.C.Rep. 101-964</u>
Medicaid - State Plans for Medical Assistance	1902(m) (1) (B)	4501(e) (2) (A)	1388-165	101-102	176, 835-837
Medicaid - State Plans for Medical Assistance	1902(m) (2) (C) New	4501(e) (2) (B)	1388-165	101-102	176, 835-837
Medicaid - State Plans for Medical Assistance	1902(r) (1)	4715(a)	1388-192	—	204, 871-877
Medicaid - State Plans for Medical Assistance	1902(r) (2) (A)	4601(a) (1) (D)	1388-166	102-103	177, 837-841
Medicaid - State Plans for Medical Assistance	1902(s) New	4604(a)	1388-168	—	179, 837-841
Medicaid - State Plans for Medical Assistance	1902(t) New	4701(b) (1)	1388-170	—	181, 866-871
Medicaid - State Plans for Medical Assistance	1902(u) New	4713(a) (2)	1388-190	—	202-203, 871-877
Medicaid - State Plans for Medical Assistance	1902(v) (1) New	4724(a)	1388-194	—	206, 871-877
Medicaid - State Plans for Medical Assistance	1902(w) New	4751(a) (2)	1388-204	137-139	216-217, 894-899
Medicaid - State Plans for Medical Assistance	1902(x) New	4752(a) (1) (A)	1388-206	—	218, 894-899
Medicaid - State Plans for Medical Assistance	1902(y)	4755(a) (2)	1388-209	—	221-222, 894-899

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Medicaid - Payment to States	1903(a) (1)	4402(d) (3)	1388- 164	99- 101	174, 833- 834
Medicaid - Payment to States	1903(a) (2) (B)	4801(a) (8)	1388- 212	108- 127	225, 841- 855
Medicaid - Payment to States (technical amendment)	1903(a) (3) (C)	4401(b) (1) (A)	1388- 159	95- 98	169, 821- 833
Medicaid - Payment to States	1903(a) (3) (D) New	4401(b) (1) (B)	1388- 159	95- 98	169, 821- 833
Medicaid - Payment to States (technical amendment)	1903(f) (2) Redesignated as 1903(f) (2) (A)	4723(a) (1)	1388- 194	—	206, 871- 877
Medicaid - Payment to States (technical amendment)	1903(f) (2) (A)	4723(a) (2)	1388- 194	—	206, 871- 877
Medicaid - Payment to States	1903(f) (2) (B) New	4723(a) (2)	1388- 194	—	206, 871- 877
Medicaid - Payment to States	1903(f) (4)	4601(a) (3) (A) (i)	1388- 166	102- 103	177, 837- 841
Medicaid - Payment to States	1903(f) (4)	4601(a) (3) (A) (ii)	1388- 166	102- 103	177, 837- 841
Medicaid - Payment to States	1903(i) (8)	4711(c) (2)	1388- 187	—	198, 855- 863
Medicaid - Payment to States (technical amendment)	1903(i) (9)	4401(a) (1) (A)	1388- 143	95- 98	152, 821- 833
Medicaid - Payment to States (technical amendment)	1903(i) (9)	4701(b) (2) (A)	1388- 70	—	181, 866- 871

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<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>104 Stat.</u>	<u>H. Rep. 101-881</u>	<u>H.C.Rep. 101-964</u>
Medicaid - Payment to States	1903(i) (9)	4801(e) (16) (A) (i)	1388- 218	108- 127	231, 841- 855
Medicaid - Payment to States	1903(i) (10) New	4401(a) (1) (B)	1388- 143	95- 98	152, 821- 833
Medicaid - Payment to States (technical amendment)	1903(i) (10)	4801(e) (16) (A) (ii)	1388- 218	108- 127	231, 841- 855
Medicaid - Payment to States	1903(i) (10) New	4701(b) (2) (B)	1388- 170	—	181, 866- 871
Medicaid - Payment to States	1903(i) (11) New	4801(e) (16) (A) (iii)	1388- 218	108- 127	231, 841- 855
Medicaid - Payment to States (technical amendment)	1903(i) (11)	4752(a) (2) (A)	1388- 206	—	218, 894- 899
Medicaid - Payment to States	1903(i) (12) New	4752(a) (2) (B)	1388- 206	—	218, 894- 899
Medicaid - Payment to States (technical amendment)	1903(i) (13)	4752(e) (1)	1388- 207	—	219, 894- 899
Medicaid - Payment to States	1903(i) (14) New	4752(e) (2)	1388- 207	—	220, 894- 899
Medicaid - Payment to States (conforming amendment)	1903(m) (1) (A)	4751(b) (1) (A)	1388- 205	—	217, 894- 899
Medicaid - Payment to States (conforming amendment)	1903(m) (1) (A)	4751(b) (1) (B)	1388- 205	—	217, 894- 899
Medicaid - Payment to States	1903(m) (2) (A) (i)	4732(d) (1)	1388- 196	—	208, 877- 881

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Subject	S.S. Act Section	P.L. Section	104 Stat.	H. Rep. 101-881	H.C.Rep. 101-964
Medicaid - Payment to States (technical amendment)	1903(m) (2) (A) (vii)	4704 (b) (1) (A)	1388- 172	—	182, 866- 871
Medicaid - Payment to States (technical amendment)	1903(m) (2) (A) (viii)	4704 (b) (1) (B)	1388- 172	—	182, 866- 871
Medicaid - Payment to States (technical amendment)	1903(m) (2) (A) (viii)	4731 (a) (1)	1388- 195	—	207, 877- 881
Medicaid - Payment to States	1903(m) (2) (A) (ix) New	4704 (b) (1) (C)	1388- 172	—	182, 866- 871
Medicaid - Payment to States (technical amendment)	1903(m) (2) (A) (ix)	4752 (b) (1) (A)	1388- 206	—	219, 894- 899
Medicaid - Payment to States	1903(m) (2) (A) (x) New	4731 (a) (3)	1388- 195	—	207, 877- 881
Medicaid - Payment to States (technical amendment)	1903(m) (2) (A) (x)	4752 (b) (1) (B)	1388- 206	—	219, 894- 899
Medicaid - Payment to States	1903(m) (2) (A) (xi) New	4752 (b) (1) (C)	1388- 206	—	219, 894- 899
Medicaid - Payment to States	1903(m) (2) (B)	4704 (b) (2)	1388- 172	—	183, 866- 871
Medicaid - Payment to States	1903(m) (2) (D) (i)	4732 (a)	1388- 195	—	207, 877- 881
Medicaid - Payment to States	1903(m) (2) (D) (ii)	4732 (a)	1388- 195	—	207, 877- 881
Medicaid - Payment to States	1903(m) (2) (F) (i)	4732 (b) (2) (A)	1388- 195	—	207, 877- 881

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<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>104 Stat.</u>	<u>H. Rep. 101-881</u>	<u>H.C.Rep. 101-964</u>
Medicaid - Payment to States	1903(m) (2) (F) (i)	4732(b) (2) (B)	1388-195	—	207, 877-881
Medicaid - Payment to States	1903(m) (2) (H) New	4732(c)	1388-195	—	207, 877-881
Medicaid - Payment to States	1903(m) (3)	4732(d) (2)	1388-196	—	208, 877-881
Medicaid - Payment to States (technical amendment)	1903(m) (5) (A) (iii)	4731(b) (2) (A)	1388-195	—	207, 877-881
Medicaid - Payment to States (technical amendment)	1903(m) (5) (A) (iv)	4731(b) (2) (B)	1388-195	—	207, 877-881
Medicaid - Payment to States	1903(m) (5) (A) (v) New	4731(b) (2) (C)	1388-195	—	207, 877-881
Medicaid - Payment to States	1903(u) (1) (C) (iv)	4402(b)	1388-163	99-101	173, 833-834
Medicaid - Definitions	1905(a) (viii)	4713(b) (1)	1388-191	—	203, 871-877
Medicaid - Definitions (technical amendment)	1905(a) (ix)	4713(b) (2)	1388-191	—	203, 871-877
Medicaid - Definitions	1905(a) (x) New	4713(b) (3)	1388-191	—	203, 871-877
Medicaid - Definitions	1905(a) (7)	4721(a)	1388-194	—	205, 871-877
Medicaid - Definitions	1905(a) (13)	4719(a)	1388-193	—	205, 871-877

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<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>104 Stat.</u>	<u>H. Rep. 101-881</u>	<u>H.C.Rep. 101-964</u>
Medicaid - Definitions (technical amendment)	1905(a) (22)	4711(a) (1)	1388- 174	—	185, 855- 863
Medicaid - Definitions (technical amendment)	1905(a) (23) Redesignated as 1905(a) (24)	4711(a) (2)	1388- 174	—	185, 855- 863
Medicaid - Definitions	1905(a) (23) New	4711(a) (3)	1388- 174	—	184, 855- 863
Medicaid - Definitions (technical amendment)	1905(a) (23)	4712(a) (1)	1388- 187	—	199, 863- 866
Medicaid - Definitions (technical amendment)	1905(a) (24) Redesignated as 1905(a) (25)	4712(a) (2)	1388- 187	—	199, 863- 866
Medicaid - Definitions	1905(a) (24) New	4712(a) (3)	1388- 187	—	199, 863- 866
Medicaid - Definitions	1905(a)	4402(d) (2)	1388- 163	99- 101	174, 833- 834
Medicaid - Definitions	1905(a)	4722	1388- 194	—	206, 871- 877
Medicaid - Definitions	1905(h) (1) (A)	4755(a) (1) (A)	1388- 209	—	221, 894- 899
Medicaid - Definitions	1905(l) (2) (A)	4704(c) (1)	1388- 172	—	183, 866- 871
Medicaid - Definitions	1905(l) (2) (B)	4704(c) (2)	1388- 172	—	183, 866- 871

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<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>104 Stat.</u>	<u>H. Rep. 101-881</u>	<u>H.C.Rep. 101-964</u>
Medicaid - Definitions (technical amendment)	1905(l) (2) (B) (ii) Redesignated as 1905(l) (2) (B) (iii)	4704(c) (3)	1388- 172	—	183, 866- 871
Medicaid - Definitions	1905(l) (2) (B) (ii) New	4704(c) (3)	1388- 172	—	183, 866- 871
Medicaid - Definitions (technical amendment)	1905(l) (2) (B)	4704(d) (1)	1388- 172	—	183, 866- 871
Medicaid - Definitions	1905(l) (2) (B)	4704(d) (2)	1388- 172	—	183, 866- 871
Medicaid - Definitions	1905(n) (2)	4601(a) (2)	1388- 166	102- 103	177, 837- 841
Medicaid - Definitions	1905(o) (1) (A)	4717	1388- 193	—	204, 871- 877
Medicaid - Definitions	1905(o) (3)	4705(a) (1)	1388- 172	—	183, 866- 871
Medicaid - Definitions	1905(o) (3) (A)	4705(a) (2)	1388- 172	—	183, 866- 871
Medicaid - Definitions	1905(o) (3) (C)	4705(a) (2)	1388- 172	—	183, 866- 871
Medicaid - Definitions	1905(o) (3)	4705(a) (3)	1388- 172	—	183, 866- 871
Medicaid - Definitions	1905(o) (3)	4705(a) (4)	1388- 172	—	183, 866- 871

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<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>104 Stat.</u>	<u>H. Rep. 101-881</u>	<u>H.C.Rep. 101-964</u>
Medicaid - Definitions	1905(p) (1) (B)	4501(e) (1) (A)	1388- 165	101- 102	175, 835- 837
Medicaid - Definitions (technical amendment)	1905(p) (2) (B) (ii)	4501(a) (1) (A)	1388- 164	101- 102	175, 835- 837
Medicaid - Definitions	1905(p) (2) (B) (iii)	4501(a) (1) (B)	1388- 165	101- 102	175, 835- 837
Medicaid - Definitions	1905(p) (2) (B) (iv) Stricken	4501(a) (1) (C)	1388- 165	101- 102	175, 835- 837
Medicaid - Definitions	1905(p) (2) (C) (iii)	4501(a) (2) (A)	1388- 164	101- 102	175, 835- 837
Medicaid - Definitions (technical amendment)	1905(p) (2) (C) (iii)	4501(a) (2) (B)	1388- 164	101- 102	175, 835- 837
Medicaid - Definitions	1905(p) (2) (C) (iv)	4501(a) (2) (C)	1388- 164	101- 102	175, 835- 837
Medicaid - Definitions	1905(p) (2) (C) (v) Stricken	4501(a) (2) (D)	1388- 164	101 102	175, 835- 837
Medicaid - Definitions	1905(p) (2) (D)	4501(e) (1) (B)	1388- 165	101- 102	175- 176, 835- 837
Medicaid - Definitions	1905(p) (4) (B)	4501(c) (1)	1388- 165	101- 102	175, 835- 837
Medicaid - Definitions	1905(p) (4)	4501(c) (2)	1388- 165	101- 102	175, 835- 837

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<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>104 Stat.</u>	<u>H. Rep. 101-881</u>	<u>H.C.Rep. 101-964</u>
Medicaid - Enrollment of Individuals Under Group Health Plans	1906 New	4402(a) (2)	1388- 161	99- 101	171- 173, 833- 834
Medicaid - State Programs for Licensing of Administrators of Nursing Homes	1908 Repealed	4801(e) (11) (B)	1388- 217	108- 127	230, 841- 855
Medicaid - Assignment of Rights of Payments	1912(a) (1) (B)	4606(a)	1388- 170	106- 107	180, 837- 841
Medicaid - Inapplicability and Waiver of Certain Requirements	1915(b)	4604(c)	1388- 169	—	179, 837- 841
Medicaid - Inapplicability and Waiver of Certain Requirements	1915(b)	4704(b) (3)	1388- 172	—	183, 866- 871
Medicaid - Inapplicability and Waiver of Certain Requirements	1915(b) (4)	4742(a)	1388- 197	—	209, 881- 893
Medicaid - Inapplicability and Waiver of Certain Requirements	1915(c) (1)	4741(a)	1388- 197	—	209, 881- 893
Medicaid - Inapplicability and Waiver of Certain Requirements	1915(c) (4)	4742(d) (1)	1388- 198	—	210, 881- 893
Medicaid - Inapplicability and Waiver of Certain Requirements	1915(c) (7) (C) New	4742(c) (1)	1388- 197	—	210, 881- 893
Medicaid - Inapplicability and Waiver of Certain Requirements	1915(d) (1)	4741(a)	1388- 197	—	209, 881- 893
Medicaid - Inapplicability and Waiver of Certain Requirements	1915(d) (5) (B) (iv)	4741(b)	1388- 197	—	209, 881- 893

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<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>104 Stat.</u>	<u>H. Rep. 101-881</u>	<u>H.C.Rep. 101-964</u>
Medicaid - Requirements for Nursing Facilities	1919(b) (1) (B)	4801(e) (2)	1388- 215	108- 127	228, 841- 855
Medicaid - Requirements for Nursing Facilities	1919(b) (3) (C) (i) (I)	4801(e) (3)	1388- 216	108- 127	228, 841- 855
Medicaid - Requirements for Nursing Facilities	1919(b) (3) (F)	4801(b) (2) (A)	1388- 213	108- 127	225, 841- 855
Medicaid - Requirements for Nursing Facilities	1919(b) (3) (F)	4801(b) (8)	1388- 215	108- 127	227, 841- 855
Medicaid - Requirements for Nursing Facilities	1919(b) (3) (F)	4801(b) (4) (A)	1388- 214	108- 127	226, 841- 855
Medicaid - Requirements for Nursing Facilities (technical amendment)	1919(b) (4) (A) (v)	4801(e) (4) (A)	1388- 216	108- 127	228, 841- 855
Medicaid - Requirements for Nursing Facilities (technical amendment)	1919(b) (4) (A) (vi)	4801(e) (4) (B)	1388- 216	108- 127	229, 841- 855
Medicaid - Requirements for Nursing Facilities	1919(b) (4) (A) (vii) New	4801(e) (4) (C)	1388- 216	108- 127	229, 841- 855
Medicaid - Requirements for Nursing Facilities	1919(b) (4) (C) (ii)	4801(e) (5) (A)	1388- 216	108- 127	229, 841 855
Medicaid - Requirements for Nursing Facilities (technical amendment)	1919(b) (4) (C) (ii) (II)	4801(e) (5) (B)	1388- 216	108- 127	229, 841- 855
Medicaid - Requirements for Nursing Facilities (technical amendment)	1919(b) (4) (C) (ii) (III)	4801(e) (5) (C)	1388- 216	108- 127	229, 841- 855
Medicaid - Requirements for Nursing Facilities	1919(b) (4) (C) (ii) (IV) New	4801(e) (5) (D)	1388- 216	108- 127	229, 841- 855

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<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>104 Stat.</u>	<u>H. Rep. 101-881</u>	<u>H.C.Rep. 101-964</u>
Medicaid - Requirements for Nursing Facilities	1919(b) (4) (C) (ii) (V) New	4801(e) (5) (D)	1388- 216	108- 127	229, 841- 855
Medicaid - Requirements for Nursing Facilities	1919(b) (5) (A)	4801(a) (2) (i)	1388- 211	108- 127	223, 841- 855
Medicaid - Requirements for Nursing Facilities	1919(b) (5) (A)	4801(a) (2) (ii)	1388- 211	108- 127	223, 841- 855
Medicaid - Requirements for Nursing Facilities	1919(b) (5) (A)	4801(a) (2) (iii)	1388- 211	108- 127	223, 841- 855
Medicaid - Requirements for Nursing Facilities	1919(b) (5) (A) (ii) New	4801(a) (2) (iv)	1388- 211	108- 127	223- 224, 841- 855
Medicaid - Requirements for Nursing Facilities	1919(b) (5) (C)	4801(a) (3)	1388- 211	108- 127	224, 841- 855
Medicaid - Requirements for Nursing Facilities	1919(b) (5) (D)	4801(a) (4)	1388- 211	108- 127	224, 841- 855
Medicaid - Requirements for Nursing Facilities	1919(b) (5) (F) (i)	4801(e) (6)	1388- 216	108- 127	229, 841- 855
Medicaid - Requirements for Nursing Facilities	1919(b) (6) (A)	4801(d) (1)	1388- 215	108- 127	228, 841- 855
Medicaid - Requirements for Nursing Facilities	1919(c) (1) (A) (iv)	4801(e) (9)	1388- 217	108- 127	230, 841- 855
Medicaid - Requirements for Nursing Facilities (technical amendment)	1919(c) (1) (A) (x) Redesignated as 1919(c) (1) (A) (xi)	4801(e) (8) (A)	1388- 217	108- 127	230, 841- 855

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<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>104 Stat.</u>	<u>H. Rep. 101-881</u>	<u>H.C.Rep. 101-964</u>
Medicaid - Requirements for Nursing Facilities	1919(c) (1) (A) (x) New	4801(e) (8) (A)	1388- 217	108- 127	230, 841- 855
Medicaid - Requirements for Nursing Facilities	1919(c) (1) (A)	4801(e) (8) (B)	1388- 217	108- 127	230, 841- 855
Medicaid - Requirements for Nursing Facilities	1919(c) (1) (B) (ii)	4801(e) (10)	1388- 217	108- 127	230, 841- 855
Medicaid - Requirements for Nursing Facilities (conforming amendment)	1919(c) (2) (E) New	4751(b) (2)	1388- 205	137- 139	217, 894- 899
Medicaid - Requirements for Nursing Facilities (technical amendment)	1919(c) (7) Redesignated as 1919(c) (8)	4801(e) (7) (A) (i)	1388- 216	108- 127	229, 841- 855
Medicaid - Requirements for Nursing Facilities	1919(c) (7) New	4801(e) (7) (A) (ii)	1388- 216	108- 127	229, 841- 855
Medicaid - Requirements for Nursing Facilities	1919(e) (1) (A)	4801(e) (18)	1388- 219	108- 127	232, 841- 855
Medicaid - Requirements for Nursing Facilities	1919(e) (2) (A)	4801(e) (12) (A)	1388- 217	108- 127	230, 841- 855
Medicaid - Requirements for Nursing Facilities	1919(e) (2) (C) New	4801(e) (12) (B)	1388- 217	108- 127	231, 841- 855
Medicaid - Requirements for Nursing Facilities	1919(e) (7)	4801(b) (8)	1388- 215	108- 127	227, 841- 855
Medicaid - Requirements for Nursing Facilities	1919(e) (7) (A)	4801(b) (2) (B) (i)	1388- 213	108- 127	225, 841- 855

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<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>104 Stat.</u>	<u>H. Rep. 101-881</u>	<u>H.C.Rep. 101-964</u>
Medicaid - Requirements for Nursing Facilities	1919(e) (7) (A) (ii) New	4801(b) (2) (B) (ii)	1388- 213	108- 127	225- 226, 841- 855
Medicaid - Requirements for Nursing Facilities	1919(e) (7) (A) (iii) New	4801(b) (2) (B) (ii)	1388- 213	108- 127	225- 226, 841- 855
Medicaid - Requirements for Nursing Facilities	1919(e) (7) (B) (iv) New	4801(b) (4) (B)	1388- 214	108- 127	226, 841- 855
Medicaid - Requirements for Nursing Facilities	1919(e) (7) (C) (iv) New	4801(b) (5) (A)	1388- 214	108- 127	227, 841- 855
Medicaid - Requirements for Nursing Facilities	1919(e) (7) (D)	4801(b) (3) (A) (i)	1388- 213	108- 127	226, 841- 855
Medicaid - Requirements for Nursing Facilities	1919(e) (7) (D) Heading	4801(b) (3) (A) (ii)	1388- 213	108- 127	226, 841- 855
Medicaid - Requirements for Nursing Facilities	1919(e) (7) (D) (ii) New	4801(b) (3) (A) (iii)	1388- 213	108- 127	226, 841- 855
Medicaid - Requirements for Nursing Facilities	1919(e) (7) (E)	4801(b) (3) (B)	1388- 213	108- 127	226, 841- 855
Medicaid - Requirements for Nursing Facilities	1919(e) (7) (E)	4801(b) (6)	1388- 214	108- 127	227, 841- 855
Medicaid - Requirements for Nursing Facilities	1919(e) (7) (G) (i)	4801(b) (7) (A)	1388- 214	108- 127	227, 841- 855
Medicaid - Requirements for Nursing Facilities	1919(e) (7) (G) (i)	4801(b) (7) (B)	1388- 214	108- 127	227, 841- 855

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<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>104 Stat.</u>	<u>H. Rep. 101-881</u>	<u>H.C.Rep. 101-964</u>
Medicaid - Requirements for Nursing Facilities (technical amendment)	1919(f) (2) (A) (iv) (I)	4801(a) (5) (A)	1388- 211	108- 127	224, 841- 855
Medicaid - Requirements for Nursing Facilities	1919(f) (2) (A) (iv) (II)	4801(a) (5) (B)	1388- 211	108- 127	224, 841- 855
Medicaid - Requirements for Nursing Facilities (technical amendment)	1919(f) (2) (A) (iv) (II)	4801(a) (5) (C)	1388- 211	108- 127	224, 841- 855
Medicaid - Requirements for Nursing Facilities	1919(f) (2) (A) (iv) (III) New	4801(a) (5) (D)	1388- 211	108- 127	224, 841- 855
Medicaid - Requirements for Nursing Facilities	1919(f) (2) (B)	4801(a) (7)	1388- 212	108- 127	225, 841- 855
Medicaid - Requirements for Nursing Facilities	1919(f) (2) (B) (iii) (I)	4801(a) (6) (A)	1388- 212	108- 127	224, 841- 855
Medicaid - Requirements for Nursing Facilities	1919(g) (1) (C)	4801(e) (13)	1388- 218	108 127	231, 841- 855
Medicaid - Requirements for Nursing Facilities	1919(g) (5) (A) (i)	4801(e) (14)	1388- 218	108- 127	231, 841- 855
Medicaid - Requirements for Nursing Facilities	1919(g) (5) (B)	4801(e) (15)	1388- 218	108- 127	231, 841- 855
Medicaid - Presumptive Eligibility for Pregnant Women (technical amendment)	1920(b) (1) (B) (i)	4605(a) (1) (A)	1388- 169	105- 106	180, 837- 841
Medicaid - Presumptive Eligibility for Pregnant Women	1920(b) (1) (B) (ii) Stricken	4605(a) (1) (B)	1388- 169	105- 106	180, 837- 841

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<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>104 Stat.</u>	<u>H. Rep. 101-881</u>	<u>H.C.Rep. 101-964</u>
Medicaid - Presumptive Eligibility for Pregnant Women	1920(b) (1) (B) (iii)	4605(a) (1) (C)	1388- 169	105- 106	180, 837- 841
Medicaid - Presumptive Eligibility for Pregnant Women	1920(c) (2) (B)	4605(a) (2)	1388- 169	105- 106	180, 837- 841
Medicaid - Presumptive Eligibility for Pregnant Women	1920(c) (3)	4605(a) (2)	1388- 169	105- 106	180, 837- 841
Medicaid - Presumptive Eligibility for Pregnant Women	1920(c) (3)	4605(b)	1388- 169	105- 106	180, 837- 841
Medicaid - Sanctions Against Health Care Practitioners and Providers	1921(a) (1)	4752(f) (1) (A)	1388- 208	—	220, 894- 899
Medicaid - Sanctions Against Health Care Practitioners and Providers	1921(a) (1) (D) New	4752(f) (1) (B)	1388- 208	—	221, 894- 899
Medicaid - Adjustment in Payment for Inpatient Hospital Services	1923(b) (2)	4702(a)	1388- 171	—	181, 866- 871
Medicaid - Adjustment in Payment for Inpatient Hospital Services (technical amendment)	1923(c) (1)	4703(a) (1)	1388- 171	—	182, 866- 871
Medicaid - Adjustment in Payment for Inpatient Hospital Services (technical amendment)	1923(c) (2)	4703(a) (2)	1388- 171	—	182, 866- 871
Medicaid - Adjustment in Payment for Inpatient Hospital Services (conforming amendment)	1923(c) (2)	4703(c)	1388- 171	—	182, 866- 871
Medicaid - Adjustment in Payment for Inpatient Hospital Services	1923(c) (3) New	4703(a) (3)	1388- 171	—	182, 866- 871

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<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>104 Stat.</u>	<u>H. Rep. 101-881</u>	<u>H.C.Rep. 101-964</u>
Medicaid - Adjustment in Payment for Inpatient Hospital Services	1923(e) (2)	4703(b)	1388- 171	—	182, 866- 871
Medicaid - Treatment of Income and Resources for Certain Institutionalized Spouses	1924(a) (5) New	4744(b) (1)	1388- 198	—	210- 211, 891- 893
Medicaid - Treatment of Income and Resources for Certain Institutionalized Spouses	1924(b) (2)	4714(a)	1388- 192	—	203, 871- 877
Medicaid - Treatment of Income and Resources for Certain Institutionalized Spouses	1924(c) (1)	4714(c)	1388- 192	—	204, 871- 877
Medicaid - Treatment of Income and Resources for Certain Institutionalized Spouses	1924(f) (1)	4714(b)	1388- 192	—	204, 871- 877
Medicaid - Extension of Eligibility	1925(a) (3) (C)	4601(a) (3) (B)	1388- 167	102- 103	177, 837- 841
Medicaid - Extension of Eligibility	1925(b) (3) (C) (i)	4601(a) (3) (B)	1388- 167	102 103	177, 837- 841
Medicaid - Extension of Eligibility	1925(f) (b) (2) (B) (i)	4716(a) (1)	1388- 192	—	204, 871- 877
Medicaid - Extension of Eligibility	1925(f) (b) (2) (B) (iii) New	4716(a) (2)	1388- 192	—	204, 871- 877
Medicaid - Extension of Eligibility	1925(f) (b) (3) (B)	4716(a) (3)	1388- 192	—	204, 871- 877

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<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>104 Stat.</u>	<u>H. Rep. 101-881</u>	<u>H.C.Rep. 101-964</u>
Medicaid - References to Laws Directly Affecting the Program (technical amendment)	1927 Redesignated as 1928	4401(a) (3)	1388- 143	95- 98	152, 821- 833
Medicaid - Payment for Covered Outpatient Drugs	1927 New	4401(a) (3)	1388- 143	--	152- 169, 821- 833
Medicaid	1929 Redesignated as 1930*	4711(b) (1)	1388- 174	--	185, 855- 863
Medicaid - Home and Community Care for Functionally Disabled Elderly Individuals	1929 New	4711(b) (2)	1388- 174	--	185, 855- 863
Medicaid	1930**	4712(b) (2)	1388- 187	--	199, 863- 866
Medicaid - Community Supported Living Arrangements Services	1930 New	4712(b) (2)	1388- 187	--	199, 863- 866

* Impossible to execute. (No section 1929 existed.)

** Impossible to execute. (No section 1930 existed.)

PUBLIC LAW 101-508—NOV. 5, 1990

OMNIBUS BUDGET RECONCILIATION
ACT OF 1990

Public Law 101-508
101st Congress

An Act

Nov. 5, 1990
[H.R. 5835]

To provide for reconciliation pursuant to section 4 of the concurrent resolution on the budget for fiscal year 1991.

Omnibus Budget
Reconciliation
Act of 1990.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the “Omnibus Budget Reconciliation Act of 1990”

SEC. 2. TABLE OF TITLES.

- Title I. Agriculture and related programs.
- Title II. Banking, housing, and related programs.
- Title III. Student loans and labor provisions.
- Title IV. Medicare, medicaid, and other health-related programs.
- Title V. Income security, human resources, and related programs.
- Title VI. Energy and environmental programs.
- Title VII. Civil service and postal service programs.
- Title VIII. Veterans' programs.
- Title IX. Transportation.
- Title X. Miscellaneous user fees and other provisions.
- Title XI. Revenue provisions.
- Title XII. Pensions.
- Title XIII. Budget enforcement.

Agricultural
Reconciliation
Act of 1990.

TITLE I—AGRICULTURE AND RELATED
PROGRAMS

SEC. 1001. SHORT TITLE; TABLE OF CONTENTS.

7 USC 1421 note.

(a) SHORT TITLE.—This title may be cited as the “Agricultural Reconciliation Act of 1990”.

(b) TABLE OF CONTENTS.—The table of contents of this title is as follows:

Sec. 1001. Short title; table of contents.

Subtitle A—Commodity Programs

- Sec. 1101. Triple base for deficiency payments.
- Sec. 1102. Calculation of deficiency payments based on 12-month average.
- Sec. 1103. Acreage reduction program for 1991 crop.
- Sec. 1104. Acreage reduction programs for 1992 through 1995 crops.
- Sec. 1105. Loan origination fees and other savings.

Subtitle B—Other Agricultural Programs

- Sec. 1201. Authorization levels for rural electric and telephone loans.
- Sec. 1202. Authorization levels for FmHA loans.
- Sec. 1203. APHIS inspection user fee on international passengers.
- Sec. 1204. Additional savings and other provisions.

Subtitle C—Effective Date

- Sec. 1301. Effective date.
- Sec. 1302. Readjustment of support levels.

ENROLLMENT ERRATA

Pursuant to the provisions of H.J. Res. 682, waiving certain enrollment requirements with respect to any reconciliation bill, appropriation bill, or continuing resolution for the remainder of the One Hundred First Congress, and providing for the subsequent preparation and certification of printed enrollments, this printed enrollment contains corrections in indentation, typeface, and type size and includes footnotes identifying obvious errors in spelling or punctuation in the hand enrollment.

TITLE IV—MEDICARE, MEDICAID, AND OTHER HEALTH-RELATED PROGRAMS

Subtitle A—Medicare

SEC. 4000. REFERENCES IN SUBTITLE; TABLE OF CONTENTS.

(a) AMENDMENTS TO THE SOCIAL SECURITY ACT.—Except as otherwise specifically provided, whenever in this title an amendment is expressed in terms of an amendment to or repeal of a section or other provision, the reference shall be considered to be made to that section or other provision of the Social Security Act.

(b) TABLE OF CONTENTS.—The table of contents of this subtitle is as follows:

Sec. 4000. References in subtitle; table of contents.

PART 1—PROVISIONS RELATING TO PART A

- Sec. 4001. Payments for capital-related costs of inpatient hospital services.
- Sec. 4002. Prospective payment hospitals.
- Sec. 4003. Expansion of DRG payment window.
- Sec. 4004. Payments for medical education costs.
- Sec. 4005. PPS-exempt hospitals.
- Sec. 4006. Hospice benefit extension.
- Sec. 4007. Freeze in payments under part A through December 31.
- Sec. 4008. Miscellaneous and technical provisions relating to part A.

PART 2—PROVISIONS RELATING TO PART B

Subpart A—Payment for Physicians' Services

- Sec. 4101. Certain overvalued procedures.
- Sec. 4102. Radiology services.
- Sec. 4103. Anesthesia services.
- Sec. 4104. Physician pathology services.
- Sec. 4105. Update for physicians' services.
- Sec. 4106. New physicians and other new health care practitioners.
- Sec. 4107. Assistants at surgery.
- Sec. 4108. Technical components of certain diagnostic tests.
- Sec. 4109. Interpretation of electrocardiograms.
- Sec. 4110. Reciprocal billing arrangements.
- Sec. 4111. Study of prepayment medical review screens.
- Sec. 4112. Practicing physicians advisory council.
- Sec. 4113. Study of aggregation rule for claims for similar physicians' services.
- Sec. 4114. Utilization screens for physician visits in rehabilitation hospitals.
- Sec. 4115. Study of regional variations in impact of medicare physician payment reform.
- Sec. 4116. Limitation on beneficiary liability.
- Sec. 4117. Statewide fee schedule areas for physicians' services.
- Sec. 4118. Technical corrections.

Subpart B—Other Items and Services

- Sec. 4151. Payments for hospital outpatient services.
- Sec. 4152. Durable medical equipment.
- Sec. 4153. Provisions relating to orthotics and prosthetics.
- Sec. 4154. Clinical diagnostic laboratory tests.
- Sec. 4155. Coverage of nurse practitioners in rural areas.
- Sec. 4156. Coverage of injectable drugs for treatment of osteoporosis.
- Sec. 4157. Separate payment under part B for services of certain health practitioners.
- Sec. 4158. Reduction in payments under part B during final 2 months of 1990.
- Sec. 4159. Payments for medical education costs.
- Sec. 4160. Certified registered nurse anesthetists.

- Sec. 4161. Community health centers and rural health clinics.
- Sec. 4162. Partial hospitalization in community mental health centers.
- Sec. 4163. Coverage of screening mammography.
- Sec. 4164. Miscellaneous and technical provisions relating to part B.

PART 3—PROVISIONS RELATING TO PARTS A AND B

- Sec. 4201. Provisions relating to end stage renal disease.
- Sec. 4202. Staff-assisted home dialysis demonstration project.
- Sec. 4203. Extension of secondary payor provisions.
- Sec. 4204. Health maintenance organizations.
- Sec. 4205. Peer review organizations.
- Sec. 4206. Medicare provider agreements assuring the implementation of a patient's right to participate in and direct health care decisions affecting the patient.
- Sec. 4207. Miscellaneous and technical provisions relating to parts A and B.

PART 4—PROVISIONS RELATING TO PART B PREMIUM AND DEDUCTIBLE

- Sec. 4301. Part B premium.
- Sec. 4302. Part B deductible.

PART 5—MEDICARE SUPPLEMENTAL INSURANCE POLICIES

- Sec. 4351. Simplification of medicare supplemental policies.
- Sec. 4352. Guaranteed renewability.
- Sec. 4353. Enforcement of standards.
- Sec. 4354. Preventing duplication.
- Sec. 4355. Loss ratios and refund of premiums.
- Sec. 4356. Clarification of treatment of plans offered by health maintenance organizations.
- Sec. 4357. Pre-existing condition limitations and limitation on medical underwriting.
- Sec. 4358. Medicare select policies.
- Sec. 4359. Health insurance advisory services for medicare beneficiaries.
- Sec. 4360. Health insurance information, counseling, and assistance grants.
- Sec. 4361. Medicare and medigap information by telephone.

PART 1—PROVISIONS RELATING TO PART A

SEC. 4001. PAYMENTS FOR CAPITAL-RELATED COSTS OF INPATIENT HOSPITAL SERVICES.

(a) **REDUCTION IN PAYMENTS FOR FISCAL YEAR 1991.**—Section 1886(g)(3)(A)(v) (42 U.S.C. 1395ww(g)(3)(A)(v)) is amended by striking “September 30, 1990” and inserting “September 30, 1991”.

(b) **IMPLEMENTATION OF PROSPECTIVE PAYMENT FOR CAPITAL-RELATED COSTS.**—Section 1886(g)(1)(A) (42 U.S.C. 1395ww(g)(1)) is amended by adding at the end the following: “Aggregate payments made under subsection (d) and this subsection during fiscal years 1992 through 1995 shall be reduced in a manner that results in a reduction (as estimated by the Secretary) in the amount of such payments equal to a 10 percent reduction in the amount of payments attributable to capital-related costs that would otherwise have been made during such fiscal year had the amount of such payments been based on reasonable costs (as defined in section 1861(v)).”

(c) **EXEMPTION FOR RURAL PRIMARY CARE HOSPITALS.**—Section 1886(g)(3)(B) is amended by striking “subsection (d)(5)(D)(iii).” and inserting “subsection (d)(5)(D)(iii) or a rural primary care hospital (as defined in section 1861(mm)(1)).”

SEC. 4002. PROSPECTIVE PAYMENT HOSPITALS.

(a) **CHANGES IN UPDATE FACTORS.**—

(1) **IN GENERAL.**—Section 1886(b)(3)(B)(i) (42 U.S.C. 1395ww(b)(3)(B)(i)) is amended—

(A) by striking “and” at the end of subclause (V);

(B) in subclause (VI)—

(i) by striking “1991” and inserting “1994”, and

(ii) by redesignating such subclause as subclause (IX);

and

(C) by inserting after subclause (V) the following new subclauses:

“(VI) for fiscal year 1991, the market basket percentage increase minus 2.0 percentage points for hospitals in all areas,

“(VII) for fiscal year 1992, the market basket percentage increase minus 1.6 percentage points for hospitals in all areas,

“(VIII) for fiscal year 1993, the market basket percentage increase minus 1.55 percentage point for hospitals in all areas, and”.

42 USC 1395ww
note.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to payments for discharges occurring on or after January 1, 1991.

(b) CHANGES IN DISPROPORTIONATE SHARE PAYMENTS.—

(1) INCREASE FOR URBAN HOSPITALS WITH MORE THAN 100 BEDS.—Section 1886(d)(5)(F)(vii) (42 U.S.C. 1395ww(d)(5)(F)(vii)) is amended—

(A) in subclause (I), by striking “greater than 20.2,” and all that follows and inserting the following: “greater than 20.2—

“(a) for discharges occurring on or after April 1, 1990, and on or before December 31, 1990, $(P-20.2)(.65) + 5.62$,

“(b) for discharges occurring on or after January 1, 1991, and on or before September 30, 1993, $(P-20.2)(.7) + 5.62$,

“(c) for discharges occurring on or after October 1, 1993, and on or before September 30, 1994, $(P-20.2)(.8) + 5.88$, and

“(d) for discharges occurring on or after October 1, 1994, $(P-20.2)(.825) + 5.88$; or”;

(B) in subclause (II), by striking “hospital, $(P-15)(.6) + 2.5$,” and inserting the following: “hospital—

“(a) for discharges occurring on or after April 1, 1990, and on or before December 31, 1990, $(P-15)(.6) + 2.5$,

“(b) for discharges occurring on or after January 1, 1991, and on or before September 30, 1993, $(P-15)(.6) + 2.5$,

“(c) for discharges occurring on or after October 1, 1993, $(P-15)(.65) + 2.5$.”.

(2) INCREASE FOR HOSPITALS WITH DISPROPORTIONATE INDIGENT CARE REVENUES.—Section 1886(d)(5)(F)(iii) (42 U.S.C. 1395ww(d)(5)(F)(iii)) is amended by striking “30 percent” and inserting “35 percent”.

(3) REPEAL OF SUNSET.—

(A) IN GENERAL.—Section 1886(d) (42 U.S.C. 1395ww(d)) is amended by striking “and before October 1, 1995,” each place it appears in paragraph (2)(C)(iv) and paragraph (5)(F)(i).

(B) CONFORMING AMENDMENTS.—(A) Section 1886(d)(5)(B)(ii) (42 U.S.C. 1395ww(d)(5)(B)) is amended to read as follows:

“(ii) For purposes of clause (i)(II), the indirect teaching adjustment factor for discharges occurring on or after May 1, 1986, is equal to $1.89 \times (((1 + r) \text{ to the } n\text{th power}) - 1)$, where ‘r’ is the ratio of the hospital’s full-time equivalent interns and residents to beds and ‘n’ equals .405.”.

(B) Section 1886(d)(3)(C)(ii) (42 U.S.C. 1395ww(d)(3)(C)(ii)) is amended by striking “occurring—” and all that follows and inserting the following: “occurring on or after October 1, 1986, of an amount equal to the estimated reduction in the payment amounts under paragraph (5)(B) that would have resulted from the enactment of the amendments made by section 9104 of the Medicare and Medicaid Budget Reconciliation Amendments of 1985 and by section 4003(a)(1) of the Omnibus Budget Reconciliation Act of 1987 if the factor described in clause (ii)(II) of paragraph (5)(B) (determined without regard to amendments made by the Omnibus Budget Reconciliation Act of 1990) were applied for discharges occurring on or after such date instead of the factor described in clause (ii) of that paragraph.”.

(4) NO RESTANDARDIZING FOR RECENT ADJUSTMENTS.—

(A) ADJUSTMENTS UNDER OBRA 1989.—Section 1886(d)(2)(C)(iv) (42 U.S.C. 1395ww(d)(2)(C)(iv)) is amended by striking the period at the end and inserting the following: “, except that the Secretary shall not exclude additional payments under such paragraph made as a result of the enactment of section 6003(c) of the Omnibus Budget Reconciliation Act of 1989.”.

(B) ADJUSTMENTS UNDER OBRA 1990.—Section 1886(d)(2)(C)(iv), as amended by subparagraph (A), is further amended by striking “1989.” and inserting “1989 or the enactment of section 4002(b) of the Omnibus Budget Reconciliation Act of 1990.”.

(5) EFFECTIVE DATE.—The amendments made by paragraphs (1), (3), and (4)(B) shall apply to discharges occurring on or after January 1, 1991, the amendment made by paragraph (2) shall apply to discharges occurring on or after October 1, 1991, and the amendment made by paragraph (4)(A) shall take effect as if included in the enactment of the Omnibus Budget Reconciliation Act of 1989.

42 USC 1395ww
note.

(c) PAYMENTS TO RURAL HOSPITALS.—

(1) PHASE-OUT OF SEPARATE AVERAGE STANDARDIZED AMOUNTS.—Section 1886(b)(3)(B)(i) (42 U.S.C. 1395ww(b)(3)(B)(i)), as amended by subsection (a)(1), is further amended—

(A) in subclause (VI), by striking “in all areas,” and inserting “in a large urban or other urban area, and the market basket percentage increase minus 0.7 percentage point for hospitals located in a rural area,”;

(B) in subclause (VII), by striking “in all areas,” and inserting “in a large urban or other urban area, and the market basket percentage increase minus 0.6 percentage point for hospitals located in a rural area,”;

(C) in subclause (VIII), by striking “in all areas, and” and inserting “in a large urban or other urban area, and the market basket percentage increase minus 0.55 for hospitals located in a rural area,”;

(D) in subclause (IX)—

(i) by striking “1994” and inserting “1996”, and

(ii) by redesignating such subclause as subclause (XI);

and

(E) by inserting after subclause (VIII) the following new subclauses:

“(IX) for fiscal year 1994, the market basket percentage increase for hospitals located in a large urban or other urban area, and the market basket percentage increase plus 1.5 percentage points for hospitals located in a rural area,

“(X) for fiscal year 1995, the market basket percentage increase for hospitals located in a large urban or other urban area, and such percentage increase for hospitals located in a rural area as will provide for the average standardized amount determined under subsection (d)(3)(A) for hospitals located in a rural area being equal to such average standardized amount for hospitals located in an urban area (other than a large urban area), and”.

(2) CONFORMING AMENDMENTS.—(A) Section 1886(b)(3)(B) (42 U.S.C. 1395ww(b)(3)) is amended—

(i) in clause (ii), by striking “(A) and (E),” and inserting “(A), (C), (D), and (E),”;

(ii) in subparagraphs (C)(ii) and (D)(ii), by striking “(B)(i)” each place it appears and inserting “(B)(ii)”.

(B) Section 1886(d) (42 U.S.C. 1395ww(d)) is amended—

(i) in paragraph (1)(A)(iii), by striking “rural, large urban, or other urban area” and inserting “large urban or other area”;

(ii) in paragraph (3)(A)—

(I) in clause (ii), by striking “the Secretary” and inserting “and ending on or before September 30, 1994, the Secretary”,

(II) by redesignating clause (iii) as clause (v), and

(III) by inserting after clause (ii) the following new clauses:

“(iii) For discharges occurring in the fiscal year beginning on October 1, 1994, the average standardized amount for hospitals located in a rural area shall be equal to the average standardized amount for hospitals located in an other urban area.

“(iv) For discharges occurring in a fiscal year beginning on or after October 1, 1995, the Secretary shall compute an average standardized amount for hospitals located in a large urban area and for hospitals located in other areas within the United States and within each region equal to the respective average standardized amount computed for the previous fiscal year under this subparagraph increased by the applicable percentage increase under subsection (b)(3)(B)(i) with respect to hospitals located in the respective areas for the fiscal year involved.”;

(iii) in paragraph (3)(B), by striking “for hospitals located in an urban area” and all that follows and inserting the following: “by a factor equal to the proportion of payments under this subsection (as estimated by the Secretary) based on DRG prospective payment amounts which are additional payments described in paragraph (5)(A) (relating to outlier payments).”;

(iv) in paragraph (3)(D)(i)—

(I) in the matter preceding subclause (I), by striking “an urban area (or,” and all that follows through “area),” and inserting “a large urban area”, and

(II) in subclause (I), by striking “an urban area” and inserting “a large urban area”;

(v) in paragraph (3)(D)(ii), by striking “a rural area” each place it appears and inserting “other areas”; and

(vi) in paragraph (8)(D)—

(I) in the first sentence, by striking “for hospitals located in an urban area”, and

(II) by striking the second sentence.

(3) **EFFECTIVE DATE.**—The amendments made by paragraph (1) and paragraph (2)(A) shall apply to payments for discharges occurring on or after January 1, 1991, and the amendments made by paragraph (2)(B) shall take effect October 1, 1994.

42 USC 1395ww
note.

(d) **AREA WAGE INDEX.**—

(1) **DETERMINATION OF AREA WAGE INDEX.**—(A) For purposes of section 1886(d)(3)(E) of the Social Security Act for discharges occurring on or after January 1, 1991, and before October 1, 1993, the Secretary of Health and Human Services shall apply an area wage index determined using the survey of the 1988 wages and wage-related costs of hospitals in the United States conducted under such section.

42 USC 1395ww
note.

(B) The Secretary shall apply the wage index described in subparagraph (A) without regard to a previous survey of wages and wage-related costs.

(2) **STUDY OF AREA WAGE INDEX ADJUSTMENTS BASED ON PROFESSIONAL OCCUPATIONAL COMPONENT.**—

(A) **STUDY.**—The Prospective Payment Assessment Commission shall examine available data from States and other sources measuring earnings and paid hours of employment of hospital workers by occupational category, and shall include in such examination an analysis of the impact of variation in occupational mix on the computation of the area wage index determined under section 1886(d)(3)(E) of the Social Security Act.

(B) **REPORT TO CONGRESS.**—In its March 1991 report, the Commission shall include recommendations regarding the feasibility and desirability of modifying such area wage index to take into account occupational mix, including variations in occupational mix resulting from differences in State codes and requirements.

(e) **EXTENSION OF REGIONAL FLOOR ON STANDARDIZED AMOUNTS.**—

(1) **IN GENERAL.**—Section 1886(d)(1)(A)(iii) (42 U.S.C. 1395ww(d)(1)(A)(iii)) is amended by striking “beginning on or after” and all that follows through “1990” and inserting “beginning on or after April 1, 1988, and ending on September 30, 1993,”.

(2) **STUDY.**—(A) The Secretary of Health and Human Services shall collect sufficient data on the input prices associated with the non-wage-related portion of the adjusted average standardized amounts established under section 1886(d)(3) of the Social Security Act to identify the extent to which variations in such amounts among hospitals located in different geographic areas are attributable to differences in such prices.

42 USC 1395ww
note.

(B) Not later than June 1, 1993, the Secretary shall submit a report to Congress analyzing such data, and shall include in such report recommendations regarding a methodology for adjusting such average standardized amounts to reflect such variations.

(C) The provisions of chapter 35 of title 44, United States Code, shall not apply to data collected by the Secretary under subparagraph (A).

42 USC 1395ww
note.

(4) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to discharges occurring on or after October 1, 1990.

(f) ELIMINATION OF HOSPITAL OFF-SET FOR SERVICES OF PHYSICIAN ASSISTANTS.—

42 USC 1395x
note.

(1) IN GENERAL.—Section 9338 of the Omnibus Budget Reconciliation Act of 1986 is amended by striking subsection (d).

42 USC 1395x
note.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect as if included in the enactment of the Omnibus Budget Reconciliation Act of 1986.

(g) RESPONSIBILITIES AND REPORTING REQUIREMENTS OF PROSPECTIVE PAYMENT ASSESSMENT COMMISSION.—

(1) EXPANSION OF RESPONSIBILITIES³.—Section 1886(e)(2) (42 U.S.C. 1395ww(e)(2)) is amended—

(A) by striking “(2)” and inserting “(2)(A)”; and

(B) by adding at the end the following new subparagraphs:

“(B) In order to promote the efficient and effective delivery of high-quality health care services, the Commission shall, in addition to carrying out its functions under subparagraph (A), study and make recommendations for each fiscal year regarding changes in each existing reimbursement policy under this title under which payments to an institution are based upon prospectively determined rates and the development of new institutional reimbursement policies under this title, including recommendations relating to payments during such fiscal year under the prospective payment system established under this section for determining payments for the operating costs of inpatient hospital services, including changes in the number of diagnosis-related groups used to classify inpatient hospital discharges under subsection (d), adjustments to such groups to reflect severity of illness, and changes in the methods by which hospitals are reimbursed for capital-related costs, together with general recommendations on the effectiveness and quality of health care delivery systems in the United States and the effects on such systems of institutional reimbursements under this title.

“(C) By not later than June 1 of each year, the Commission shall submit a report to Congress containing an examination of issues affecting health care delivery in the United States, including issues relating to—

“(i) trends in health care costs;

“(ii) the financial condition of hospitals and the effect of the level of payments made to hospitals under this title on such condition;

“(iii) trends in the use of health care services; and

“(iv) new methods used by employers, insurers, and others to constrain growth in health care costs.”.

(2) REPORTING REQUIREMENTS FOR COMMISSION AND SECRETARY; ELIMINATION OF OTA REPORTING REQUIREMENTS.—Section 1886 (42 U.S.C. 1395ww) is amended—

(A) by striking subparagraph (D) of subsection (d)(4);

(B) in the second sentence of subsection (e)(2)(A), as amended by paragraph (1)(A), by striking “In addition” and all that follows through “the Commission” and inserting “The Commission”;

(C) in subsection (e)(3)(A)—

(i) by striking “the Secretary” and inserting “Congress”, and

³ So in original. Probably should be “RESPONSIBILITIES”.

(ii) by striking the period at the end and inserting the following: “, together with its general recommendations under paragraph (2)(B) regarding the effectiveness and quality of health care delivery systems in the United States.”;

(D) in subsection (e)(4)—

(i) by striking “(4)” and inserting “(4)(A)”, and

(ii) by adding at the end the following new subparagraph:

“(B) In addition to the recommendation made under subparagraph (A), the Secretary shall, taking into consideration the recommendations of the Commission under paragraph (2)(B), recommend for each fiscal year (beginning with fiscal year 1992) other appropriate changes in each existing reimbursement policy under this title under which payments to an institution are based upon prospectively determined rates.”;

(E) in subsection (e)(5)—

(i) by striking “recommendation” each place it appears and inserting “recommendations”, and

(ii) by adding at the end the following new sentence: “To the extent that the Secretary’s recommendations under paragraph (4) differ from the Commission’s recommendations for that fiscal year, the Secretary shall include in the publication referred to in subparagraph (A) an explanation of the Secretary’s grounds for not following the Commission’s recommendations.”; and

(F) in subsection (e)(6)(G)—

(i) by striking clause (i), and

(ii) by redesignating clauses (ii) and (iii) as clauses (i) and (ii).

(3) CONFORMING AMENDMENT.—Section 1845(c)(1)(D) (42 U.S.C. 1395w-1(c)(1)(D)) is amended by striking “reports and”.

(4) PROPAC STUDY OF MEDICAID PAYMENTS TO HOSPITALS.—

(A) STUDY.—The Prospective Payment Assessment Commission shall conduct a study of hospital payment rates under State plans for medical assistance under title XIX of the Social Security Act, and shall specifically examine in such study the relationship between payments under such plans and payments made to hospitals under title XVIII of such Act, and the financial condition of hospitals receiving payments under such plans, with particular attention to hospitals in urban areas which treat large numbers of individuals eligible for medical assistance under title XIX of such Act and other low-income individuals.

(B) REPORT.—By not later than October 1, 1991, the Commission shall submit a report to Congress on the study conducted under subparagraph (A) and shall include in such report such recommendations relating to requirements for payments to hospitals under title XIX of such Act as the Commission deems appropriate.

(5) EFFECTIVE DATE.—The amendments made by this subsection shall take effect on the date of the enactment of this Act.

42 USC 1395ww
note.

(h) PROVISIONS RELATING TO GEOGRAPHIC CLASSIFICATION OF HOSPITALS.—

(1) PAYMENTS TO RECLASSIFIED HOSPITALS.—

(A) IN GENERAL.—Section 1886(d)(8)(C) (42 U.S.C. 1395ww(d)(8)(C)) is amended—

(i) in clause (i), in the matter preceding subclause (I), by striking “area—” and inserting “area, or by treating hospitals located in one urban area as being located in another urban area—”;

(ii) by amending clause (i)(II) to read as follows:

“(II) reduces the wage index for that urban area by more than 1 percentage point (as applied under this subsection), the Secretary shall calculate and apply such wage index under this subsection separately to hospitals located in such urban area (excluding all the hospitals so treated) and to the hospitals so treated (as if such hospitals were located in such urban area).”;

(iii) by striking clause (ii); and

(iv) by redesignating clauses (iii) and (iv) as clauses (ii) and (iii).

(B) **EFFECTIVE DATE.**—The amendments made by subparagraph (A) shall apply to discharges occurring on or after January 1, 1991.

(2) **GEOGRAPHIC CLASSIFICATION REVIEW BOARD.**—

(A) **DEADLINE FOR SUBMISSION OF APPLICATIONS.**—For purposes of determining whether a hospital requesting a change in geographic classification for fiscal year 1992 under section 1886(d)(10) of the Social Security Act has met the deadline described in subparagraph (C)(ii) of such section, an application submitted under such subparagraph shall be considered to have been submitted by the first day of the preceding fiscal year if it is submitted within 60 days of the date of publication of the guidelines described in subparagraph (D)(i) of such section.

(B) **TECHNICAL CORRECTIONS.**—Section 1886(d)(10) (42 U.S.C. 1395ww(d)(10)) is amended—

(i) in subparagraph (A), by striking “Geographical” and inserting “Geographic”;

(ii) in subparagraph (B)(i)—

(I) by striking “representatives” and inserting “representative”, and

(II) by striking “1 member shall be a member of the Prospective Payment Assessment Commission, and at least”;

(iii) in subparagraph (B)(ii), by striking “all” and inserting “initial”; and

(iv) in subparagraph (10)(C)(iii)(II)—

(I) by striking the first 2 sentences and inserting the following: “Appeal of decisions of the Board shall be subject to the provisions of section 557b of title 5, United States Code.”, and

(II) by striking “after” and inserting “after the date on which”.

SEC. 4003. EXPANSION OF DRG PAYMENT WINDOW.

(a) **IN GENERAL.**—The first sentence of section 1886(a)(4) (42 U.S.C. 1395ww(a)(4)) is amended by striking the period and inserting the following: “, and includes the costs of all services for which payment may be made under this title that are provided by the hospital (or by an entity wholly owned or operated by the hospital) to the patient during the 3 days immediately preceding the date of the patient’s admission if such services are diagnostic services (including clinical

42 USC 1395ww
note.

42 USC 1395ww
note.

diagnostic laboratory tests) or are other services related to the admission (as defined by the Secretary).”.

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall apply—

42 USC 1395ww
note.

(1) in the case of any services provided during the day immediately preceding the date of a patient's admission (without regard to whether the services are related to the admission), to services furnished on or after the date of the enactment of this Act and before October 1, 1991;

(2) in the case of diagnostic services (including clinical diagnostic laboratory tests), to services furnished on or after January 1, 1991; and

(3) in the case of any other services, to services furnished on or after October 1, 1991.

(c) **ISSUANCE OF INTERIM FINAL REGULATION.**—The Secretary of Health and Human Services shall issue such regulations (on an interim or other basis) as may be necessary to implement this section.

42 USC 1395ww
note.

SEC. 4004. PAYMENTS FOR MEDICAL EDUCATION COSTS.

42 USC 1395ww
note.

(a) **HOSPITAL GRADUATE MEDICAL EDUCATION RECOUPMENT.**—

(1) **IN GENERAL.**—The Secretary of Health and Human Services may not, before October 1, 1991, recoup payments from a hospital because of alleged overpayments to such hospital under part A of title XVIII of the Social Security Act due to a determination that the amount of payments made for graduate medical education programs exceeds the amount allowable under section 1886(h).

(2) **CAP ON ANNUAL AMOUNT OF RECOUPMENT.**—With respect to overpayments to a hospital described in paragraph (1), the Secretary may not recoup more than 25 percent of the amount of such overpayments from the hospital during a fiscal year.

(3) **EFFECTIVE DATE.**—Paragraphs (1) and (2) shall take effect October 1, 1990.

(b) **UNIVERSITY HOSPITAL NURSING EDUCATION.**—

(1) **IN GENERAL.**—The reasonable costs incurred by a hospital (or by an educational institution related to the hospital by common ownership or control) during a cost reporting period for clinical training (as defined by the Secretary) conducted on the premises of the hospital under approved nursing and allied health education programs that are not operated by the hospital shall be allowable as reasonable costs under part A of title XVIII of the Social Security Act and reimbursed under such part on a pass-through basis.

(2) **CONDITIONS FOR REIMBURSEMENT.**—The reasonable costs incurred by a hospital during a cost reporting period shall be reimbursable pursuant to paragraph (1) only if—

(A) the hospital claimed and was reimbursed for such costs during the most recent cost reporting period that ended on or before October 1, 1989;

(B) the proportion of the hospital's total allowable costs that is attributable to the clinical training costs of the approved program, and allowable under (b)(1) during the cost reporting period does not exceed the proportion of total allowable costs that were attributable to the clinical training costs during the cost reporting period described in subparagraph (A);

(C) the hospital receives a benefit for the support it furnishes to such program through the provision of clinical services by nursing or allied health students participating in such program; and

(D) the costs incurred by the hospital for such program do not exceed the costs that would be incurred by the hospital if it operated the program itself.

(3) PROHIBITION AGAINST RECOUPMENT OF COSTS BY SECRETARY.—

(A) **IN GENERAL.**—The Secretary of Health and Human Services may not recoup payments from (or otherwise reduce or adjust payments under part A of title XVIII of the Social Security Act to) a hospital because of alleged overpayments to such hospital under such title due to a determination that costs which were reported by the hospital on its medicare cost reports for cost reporting periods beginning on or after October 1, 1983, and before October 1, 1990, relating to approved nursing and allied health education programs did not meet the requirements for allowable nursing and allied health education costs (as developed by the Secretary pursuant to section 1861(v) of such Act).

(B) **REFUND OF AMOUNTS RECOUPED.**—If, prior to the date of the enactment of this Act, the Secretary has recouped payments from (or otherwise reduced or adjusted payments under part A of title XVIII of the Social Security Act to) a hospital because of overpayments described in subparagraph (A), the Secretary shall refund the amount recouped, reduced, or adjusted from the hospital.

(4) **SPECIAL AUDIT TO DETERMINE COSTS.**—In determining the amount of costs incurred by, claimed by, and reimbursed to, a hospital for purposes of this subsection, the Secretary shall conduct a special audit (or use such other appropriate mechanism) to ensure the accuracy of such past claims and payments.

(5) **EFFECTIVE DATE.**—Except as provided in paragraph (3), the provisions of this subsection shall apply to cost reporting periods beginning on or after October 1, 1990.

SEC. 4005. PPS-EXEMPT HOSPITALS.

(a) ADJUSTMENT TO PAYMENT AMOUNTS.—

(1) **IN GENERAL.**—Section 1886(b)(1)(B) (42 U.S.C. 1395ww(b)(1)(B)) is amended by striking “(ii) in the case of” and all that follows through the semicolon and inserting the following: “(ii) in the case of cost reporting periods beginning on or after October 1, 1991, an additional amount equal to 50 percent of the amount by which the operating costs exceed the target amount (except that such additional amount may not exceed 10 percent of the target amount) after any exceptions or adjustments are made to such target amount for the cost reporting period;”.

(2) **EFFECTIVE DATE.**—The amendment made by paragraph (1) shall apply to cost reporting periods beginning on or after October 1, 1991.

(b) DEVELOPMENT OF NATIONAL PROSPECTIVE PAYMENT RATES FOR CURRENT NON-PPS HOSPITALS.—

(1) **DEVELOPMENT OF PROPOSAL.**—The Secretary of Health and Human Services shall develop a proposal to modify the current system under which hospitals that are not subsection (d) hos-

42 USC 1395ww
note.

42 USC 1395ww
note.

pitals (as defined in section 1886(d)(1)(B) of the Social Security Act) receive payment for the operating and capital-related costs of inpatient hospital services under part A of the medicare program or a proposal to replace such system with a system under which such payments would be made on the basis of nationally-determined average standardized amounts. In developing any proposal under this paragraph to replace the current system with a prospective payment system, the Secretary shall—

(A) take into consideration the need to provide for appropriate limits on increases in expenditures under the medicare program;

(B) provide for adjustments to prospectively determined rates to account for changes in a hospital's case mix, severity of illness of patients, volume of cases, and the development of new technologies and standards of medical practice;

(C) take into consideration the need to increase the payment otherwise made under such system in the case of services provided to patients whose length of stay or costs of treatment greatly exceed the length of stay or cost of treatment provided for under the applicable prospectively determined payment rate;

(D) take into consideration the need to adjust payments under the system to take into account factors such as a disproportionate share of low-income patients, costs related to graduate medical education programs, differences in wages and wage-related costs among hospitals located in various geographic areas, and other factors the Secretary considers appropriate; and

(E) provide for the appropriate allocation of operating and capital-related costs of hospitals not subject to the new prospective payment system and distinct units of such hospitals that would be paid under such system.

(2) REPORTS.—(A) By not later than April 1, 1992, the Secretary shall submit the proposal developed under paragraph (1) to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives.

(B) By not later than June 1, 1992, the Prospective Payment Assessment Commission shall submit an analysis of and comments on the proposal developed under paragraph (1) to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives.

(c) APPEALS OF TARGET AMOUNTS.—

(1) DEADLINES FOR REVIEW AND DECISION.—(A) Section 1816(f) (42 U.S.C. 1395h(f)) is amended—

(i) by striking “(1)” and “(2)” and inserting “(A)” and “(B)”;

(ii) by striking “(f)” and inserting “(f)(1)”; and

(iii) by striking “Such standards and criteria” and all that follows and inserting the following:

“(2) The standards and criteria established under paragraph (1) shall include—

“(A) with respect to claims for services furnished under this part by any provider of services other than a hospital—

“(i) whether such agency or organization is able to process 75 percent of reconsiderations within 60 days (except in

the case of fiscal year 1989, 66 percent of reconsiderations) and 90 percent of reconsiderations within 90 days, and

“(ii) the extent to which such agency or organization’s determinations are reversed on appeal; and

“(B) with respect to applications for an exemption from or exception or adjustment to the target amount applicable under section 1886(b) to a hospital that is not a subsection (d) hospital (as defined in section 1886(d)(1)(B))—

4“(i) if such agency or organization receives a completed application, whether such agency or organization is able to process such application not later than 75 days after the application is filed, and

“(ii) if such agency or organization receives an incomplete application, whether such agency or organization is able to return the application with instructions on how to complete the application not later than 60 days after the application is filed.”.

(B) Section 1886(b)(4)(A) (42 U.S.C. 1395ww(b)(4)(A)) is amended by adding at the end the following new sentence: “The Secretary shall announce a decision on any request for an exemption, exception, or adjustment under this paragraph not later than 180 days after receiving a completed application from the intermediary for such exemption, exception, or adjustment, and shall include in such decision a detailed explanation of the grounds on which such request was approved or denied.”.

(2) STANDARDS FOR ASSIGNMENT OF NEW BASE PERIOD.—Section 1886(b)(4) (42 U.S.C. 1395ww(b)(4)) is amended—

(A) by redesignating subparagraph (B) as subparagraph (C); and

(B) by inserting after subparagraph (A) the following new subparagraph:

“(B) In determining under subparagraph (A) whether to assign a new base period which is more representative of the reasonable and necessary cost to a hospital of providing inpatient services, the Secretary shall take into consideration—

“(i) changes in applicable technologies and medical practices, or differences in the severity of illness among patients, that increase the hospital’s costs;

“(ii) whether increases in wages and wage-related costs for hospitals located in the geographic area in which the hospital is located exceed the average of the increases in such costs paid by hospitals in the United States; and

“(iii) such other factors as the Secretary considers appropriate in determining increases in the hospital’s costs of providing inpatient services.”.

42 USC 1395ww
note.

(3) GUIDANCE TO INTERMEDIARIES AND HOSPITALS.—The Administrator of the Health Care Financing Administration shall provide guidance to agencies and organizations performing functions pursuant to section 1816 of the Social Security Act and to hospitals that are not subsection (d) hospitals (as defined in section 1886(d)(1)(B) of such Act) to assist such agencies, organizations, and hospitals in filing complete applications with the Administrator for exemptions, exceptions, and adjustments under section 1886(b)(4)(A) of such Act.

42 USC 1395ww
note.

(4) EFFECTIVE DATES.—The amendments made by paragraph (1) shall take effect on the date of the enactment of this Act, and the amendments made by paragraph (2) shall take effect as if

⁴ So in original. Probably should be ““(i)”.

included in the enactment of the Omnibus Budget Reconciliation Act of 1989.

SEC. 4006. HOSPICE BENEFIT EXTENSION.

(a) **IN GENERAL.**—Section 1812 (42 U.S.C. 1395d) is amended—

(1) in subsection (a)(4), by striking “90 days each” and all that follows through “with respect to” and inserting the following: “90 days each, a subsequent period of 30 days, and a subsequent extension period with respect to”; and

(2) in subsection (d)—

(A) in paragraph (1), by striking “90 days each” and all that follows through “lifetime” and inserting the following: “90 days each, a subsequent period of 30 days, and a subsequent extension period during the individual’s lifetime”, and

(B) in paragraph (2)(B), by striking “a 90- or 30-day period,” and inserting “a 90- or 30-day period or a subsequent extension period,”.

(b) **CONFORMING AMENDMENT.**—Section 1814(a)(7)(A) (42 U.S.C. 1395f(a)(7)(A)) is amended—

(1) in clause (i), by striking “and” at the end;

(2) in clause (ii), by striking the semicolon at the end and inserting “, and”; and

(3) by adding at the end the following new clause:

“(iii) in a subsequent extension period, the medical director or physician described in clause (i)(II) recertifies at the beginning of the period that the individual is terminally ill;”.

(c) **EFFECTIVE DATE.**—The amendments made by this section shall apply with respect to care and services furnished on or after January 1, 1990. 42 USC 1395d note.

SEC. 4007. FREEZE IN PAYMENTS UNDER PART A THROUGH DECEMBER 31. 42 USC 1395ww note.

(a) **IN GENERAL.**—Notwithstanding any other provision of law, for purposes of determining the amount of payment for items or services under part A of title XVIII of the Social Security Act (including payments under section 1886 of such Act attributable to or allocated under such part) during the period described in subsection (b):

(1) The market basket percentage increase (described in section 1886(b)(3)(B)(iii) of the Social Security Act) shall be deemed to be 0 for discharges occurring during such period.

(2) The percentage increase or decrease in the medical care expenditure category of the consumer price index applicable under section 1814(i)(2)(B) of such Act shall be deemed to be 0.

(3) The area wage index applicable to a subsection (d) hospital under section 1886(d)(3)(E) of such Act shall be deemed to be the area wage index applicable to such hospital as of September 30, 1990.

(4) The percentage change in the consumer price index applicable under section 1886(h)(2)(D) of such Act shall be deemed to be 0.

(b) **DESCRIPTION OF PERIOD.**—The period referred to in subsection (a) is the period beginning on October 21, 1990, and ending on December 31, 1990.

SEC. 4008. MISCELLANEOUS AND TECHNICAL PROVISIONS RELATING TO PART A.

(a) WAIVER OF LIABILITY FOR SKILLED NURSING FACILITIES AND HOSPICES.—

42 USC 1395y
note.

(1) SKILLED NURSING FACILITIES.—The second sentence of section 9126(c) of the Consolidated Omnibus Budget Reconciliation Act of 1985 is amended by striking “October 31, 1990” and inserting “December 31, 1995”.

42 USC 1395y
note.

(2) HOSPICES.—Section 9305(f)(2) of the Omnibus Budget Reconciliation Act of 1986 is amended by striking “November 1, 1990” and inserting “December 31, 1995”.

42 USC 1395y
note.

(3) EFFECTIVE DATE.—The amendments made by paragraphs (1) and (2) shall take effect on the date of the enactment of this Act.

(b) HOSPITAL OBLIGATIONS WITH RESPECT TO TREATMENT OF EMERGENCY MEDICAL CONDITIONS.—

(1) CIVIL MONETARY PENALTIES.—Section 1867(d)(2)(A) (42 U.S.C. 1395dd(d)(2)(A)) is amended by striking “knowingly” and inserting “negligently”.

(2) APPLICATION OF PENALTIES TO SMALL HOSPITALS.—Section 1867(d)(2)(A) (42 U.S.C. 1395dd(d)(2)(A)) is amended by inserting “(or not more than \$25,000 in the case of a hospital with less than 100 beds)” after “\$50,000”.

(3) TERMINATION OF HOSPITAL PROVIDER AGREEMENTS.—

(A) Section 1867 (42 U.S.C. 1395dd) is further amended—

(i) by striking paragraph (1) of subsection (d),

(ii) by redesignating paragraphs (2) and (3) of subsection (d) as paragraph (1) and (2), respectively, and

(iii) in subsection (c)(2)(C), by striking “(d)(2)(C)” and inserting “(d)(1)(C)”.

(B) Section 1866(a)(1)(I)(i) (42 U.S.C. 1395cc(a)(1)(I)(i)) is amended by inserting “and to meet the requirements of such section” before the comma at the end.

42 USC 1395cc
note.

(4) EFFECTIVE DATE.—The amendments made by this subsection shall apply to actions occurring on or after the first day of the sixth month beginning after the date of the enactment of this Act.

42 USC 1395dd
note.

(c) INSPECTOR GENERAL STUDY OF PROHIBITION ON HOSPITAL EMPLOYMENT OF PHYSICIANS.—

(1) STUDY.—The Secretary of Health and Human Services (acting through the Inspector General of the Department of Health and Human Services) shall conduct a study of the effect of State laws prohibiting the employment of physicians by hospitals on the availability and accessibility of trauma and emergency care services, and shall include in such study an analysis of the effect of such laws on the ability of hospitals to meet the requirements of section 1867 of the Social Security Act relating to the examination and treatment of individuals with an emergency medical condition and women in labor.

(2) REPORT.—By not later than 1 year after the date of the enactment of this Act, the Secretary shall submit a report to Congress on the study conducted under paragraph (1).

(d) DESIGNATION OF RURAL PRIMARY CARE HOSPITALS.—

(1) PRIORITY DESIGNATIONS OF BORDER STATE HOSPITALS.—Section 1820(i)(2)(C) (42 U.S.C. 1395i-4(i)(2)(C)) is amended by adding at the end the following new sentence: “In designating facilities

as rural primary care hospitals under this subparagraph, the Secretary shall give preference to facilities not meeting the requirements of clause (i) of subparagraph (A) that have entered into an agreement described in subsection (g)(2) with a rural health network located in a State receiving a grant under subsection (a)(1).”.

(2) **ELIGIBILITY OF CERTAIN CLOSED HOSPITALS.**—Section 1820(f)(1)(B) (42 U.S.C. 1395i-4(f)(1)(B)) is amended by striking “is a hospital,” and inserting the following: “is a hospital (or, in the case of a facility that closed during the 12-month period that ends on the date the facility applies for such designation, at the time the facility closed),”.

(3) **ELIGIBILITY OF URBAN HOSPITALS.**—Section 1820(f)(1)(A) (42 U.S.C. 1395i-4(f)(1)(A)) is amended by striking the semicolon and inserting the following: “, or is located in a county whose geographic area is substantially larger than the average geographic area for urban counties in the United States and whose hospital service area is characteristic of service areas of hospitals located in rural areas;”.

(4) **EFFECTIVE DATE.**—The amendments made by paragraphs (1), (2), and (3) shall take effect on the date of the enactment of this Act. 42 USC 1395i-4 note.

(e) **SKILLED NURSING FACILITY ROUTINE COST LIMITS.**—

(1) **IN GENERAL.**—Section 6024 of the Omnibus Budget Reconciliation Act of 1989 is amended by adding at the end the following new sentence: “The Secretary shall update such costs under such section for cost reporting periods beginning on or after October 1, 1989, by using cost reports submitted by skilled nursing facilities for cost reporting periods ending not earlier than January 31, 1988, and not later than December 31, 1988.”. 42 USC 1395yy note.

(2) **2-YEAR UPDATES REQUIRED.**—Section 1888(a) (42 U.S.C. 1395yy(a)) is amended in the matter following paragraph (4) by striking the period and inserting the following: “, and shall, for cost reporting periods beginning on or after October 1, 1992 and every 2 years thereafter, provide for an update to the per diem cost limits described in this subsection”.

(3) **EFFECTIVE DATE.**—The amendments made by paragraphs (1) and (2) shall take effect as if included in the enactment of the Omnibus Budget Reconciliation Act of 1989. 42 USC 1395yy note.

(f) **CLARIFICATION OF EXTENSION OF WAIVER FOR FINGER LAKES AREA HOSPITAL CORPORATION.**—

(1) **IN GENERAL.**—The second sentence of section 1886(c)(4) (42 U.S.C. 1395ww(c)(4)) is amended by striking “rate of increase from” and inserting “payments under the State system as compared to aggregate payments which would have been made under the national system since”.

(2) **EFFECTIVE DATE.**—The amendment made by paragraph (1) shall take effect as if included in the enactment of the Omnibus Budget Reconciliation Act of 1989. 42 USC 1395ww note.

(g) **ENROLLMENT IN PART A FOR HMO MEMBERS.**—

(1) **IN GENERAL.**—Section 1818(c) (42 U.S.C. 1395i-2(c)) is amended—

(A) by striking “and” at the end of paragraph (5),

(B) by striking the period at the end of paragraph (6) and inserting a semicolon, and

(C) by adding at the end the following new paragraphs:

“(7) an individual who meets the conditions of subsection (a) may enroll under this part during a special enrollment period that includes any month during any part of which the individual is enrolled under section 1876 with an eligible organization and ending with the last day of the 8th consecutive month in which the individual is at no time so enrolled;

“(8) in the case of an individual who enrolls during a special enrollment period under paragraph (7)—

“(A) in any month of the special enrollment period in which the individual is at any time enrolled under section 1876 with an eligible organization or in the first month following such a month, the coverage period shall begin on the first day of the month in which the individual so enrolls (or, at the option of the individual, on the first day of any of the following three months), or

“(B) in any other month of the special enrollment period, the coverage period shall begin on the first day of the month following the month in which the individual so enrolls; and

“(9) in applying the provisions of section 1839(b), there shall not be taken into account months for which the individual can demonstrate that the individual was enrolled under section 1876 with an eligible organization.”.

42 USC 1395i-2
note.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on February 1, 1991.

(h) NURSING HOME REFORM.—

42 USC 1395aa
note.

(1) NURSE AIDE TRAINING AND COMPETENCY EVALUATION.—

(A) NO COMPLIANCE ACTIONS BEFORE EFFECTIVE DATE OF GUIDELINES.—The Secretary of Health and Human Services may not refuse to enter into an agreement or cancel an existing agreement with a State under section 1864 of the Social Security Act on the basis that the State failed to meet the requirement of section 1819(e)(1)(A) of such Act before the effective date of guidelines, issued by the Secretary, establishing requirements under section 1819(f)(2)(A) of such Act, if the State demonstrates to the satisfaction of the Secretary that it has made a good faith effort to meet such requirement before such effective date.

42 USC 1395i-3.

(B) PART-TIME NURSE AIDES NOT ALLOWED DELAY IN TRAINING.—Section 1819(b)(5)(A) (42 U.S.C. 1396r(b)(5)(A)) is amended—

(i) by striking “A skilled nursing facility” and inserting “(i) Except as provided in clause (ii), a skilled nursing facility”;

(ii) by striking “(on a full-time, temporary, per diem, or other basis) and inserting “on a full-time basis”;

(iii) by striking “(i)” and “(ii)” and inserting “(I)” and “(II)”;

(iv) by adding at the end the following:

“(ii) A skilled nursing facility must not use on a temporary, per diem, leased, or on any basis other than as a permanent employee any individual as a nurse aide in the facility on or after January 1, 1991, unless the individual meets the requirements described in clause (i).”.

(C) REQUIREMENT TO OBTAIN INFORMATION FROM NURSE AIDE REGISTRY.—Section 1819(b)(5)(C) (42 U.S.C. 1395i-

3(b)(5)(C)) is amended by striking “the State registry established under subsection (e)(2)(A) as to information in the registry” and inserting “any State registry established under subsection (e)(2)(A) that the facility believes will include information”.

(D) **RETRAINING OF NURSE AIDES.**—Section 1819(b)(5)(D) (42 U.S.C. 1395i-3(b)(5)(D)) is amended by striking the period at the end and inserting “, or a new competency evaluation program.”.

(E) **CLARIFICATION OF NURSE AIDES NOT SUBJECT TO CHARGES.**—Section 1819(f)(2)(A)(iv) (42 U.S.C. 1395i-3(f)(2)(A)(iv)) is amended—

- (i) in subclause (I), by striking “and” at the end;
- (ii) in subclause (II), by inserting after “nurse aide” the following: “who is employed by (or who has received an offer of employment from) a facility on the date on which the aide begins either such program”;
- (iii) in subclause (II), by striking the period at the end and inserting “, and”; and
- (iv) by adding at the end the following new subclause:
 “(III) in the case of a nurse aide not described in subclause (II) who is employed by (or who has received an offer of employment from) a facility not later than 12 months after completing either such program, the State shall provide for the reimbursement of costs incurred in completing such program on a prorata basis during the period in which the nurse aide is so employed.”.

(F) **MODIFICATION OF NURSING FACILITY DEFICIENCY STANDARDS.**—

(i) **IN GENERAL.**—Section 1819(f)(2)(B)(iii)(I) (42 U.S.C. 1395i-3(f)(2)(B)(iii)(I)) is amended to read as follows:

“(I) offered by or in a skilled nursing facility which, within the previous 2 years—

“(a) has operated under a waiver under subsection (b)(4)(C)(ii)(II);

“(b) has been subject to an extended (or partial extended) survey under subsection (g)(2)(B)(i) or section 1919(g)(2)(B)(i); or

“(c) has been assessed a civil money penalty described in subsection (h)(2)(B)(ii) or section 1919(h)(2)(A)(ii) of not less than \$5,000, or has been subject to a remedy described in clauses (i) or (iii) of subsection (h)(2)(B), subsection (h)(4), section 1919(h)(1)(B)(i), or in clauses (i), (iii), or (iv) of section 1919(h)(2)(A), or”.

(ii) **EFFECTIVE DATE.**—The amendments made by clause (i) shall take effect as if included in the enactment of the Omnibus Budget Reconciliation Act of 1987, except that a State may not approve a training and competency evaluation program or a competency evaluation program offered by or in a nursing facility which, pursuant to any Federal or State law within the 2-year period beginning on October 1, 1988—

(I) had its participation terminated under title XVIII of the Social Security Act or under the State plan under title XIX of such Act;

42 USC 1395i-3
note.

(II) was subject to a denial of payment under either such title;

(III) was assessed a civil money penalty not less than \$5,000 for deficiencies in nursing facility standards;

(IV) operated under a temporary management appointed to oversee the operation of the facility and to ensure the health and safety of the facility's residents; or

(V) pursuant to State action, was closed or had its residents transferred.

(G) **CLARIFICATION OF STATE RESPONSIBILITY TO DETERMINE COMPETENCY.**—Section 1819(f)(2)(B) (42 U.S.C. 1395i-3(f)(2)(B)) is amended in the second sentence by inserting “(through subcontract or otherwise)” after “may not delegate”.

(H) **EFFECTIVE DATE.**—Except as provided in subparagraph (F), the amendments made by this subsection shall take effect as if they were included in the enactment of the Omnibus Budget Reconciliation Act of 1987.

(2) OTHER AMENDMENTS.—

(A) **ASSURANCE OF APPROPRIATE PAYMENT AMOUNTS.**—(i) Section 1861(v)(1)(E) (42 U.S.C. 1395x(v)(1)(E)) is amended in the second sentence by striking “the costs of such facilities” and inserting “the costs (including the costs of services required to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident eligible for benefits under this title) of such facilities”.

(ii) Section 1888(d)(1) (42 U.S.C. 1395xx(d)(1)) is amended in the first sentence by striking “(and capital-related costs)” and inserting “(including the costs of services required to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident eligible for benefits under this title) and capital-related costs”.

(B) **DISCLOSURE OF INFORMATION OF QUALITY ASSESSMENT AND ASSURANCE COMMITTEES.**—Section 1819(b)(1)(B) (42 U.S.C. 1395i-3(b)(1)(B)) is amended by adding at the end the following new sentence: “A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this subparagraph.”.

(C) **PERIOD FOR RESIDENT ASSESSMENT.**—Section 1819(b)(3)(C)(i)(I) (42 U.S.C. 1395i-3(b)(3)(C)(i)(I)) is amended by striking “4 days” and inserting “not later than 14 days”.

(D) **CLARIFICATION OF RESPONSIBILITY FOR SERVICES FOR MENTALLY ILL AND MENTALLY RETARDED RESIDENTS.**—Section 1819(b)(4)(A) (42 U.S.C. 1395i-3(b)(4)(A)) is amended—

(i) by striking “and” at the end of clause (v),

(ii) by striking the period at the end of clause (vi) and inserting “; and”, and

(iii) by inserting after clause (vi) the following new clause:

“(vii) treatment and services required by mentally ill and mentally retarded residents not otherwise provided or arranged for (or required to be provided or arranged for) by the State.”.

42 USC 1395i-3
note.

42 USC 1395yy.

(E) NOTIFICATION OF SECRETARIAL WAIVER.—Section 1819(b)(4)(C)(ii) (42 U.S.C. 1395i-3(b)(4)(C)(ii)) is amended—

- (i) by striking “and” at the end of subclause (II);
- (ii) by striking the period at the end of subclause (III) and inserting a comma; and
- (iii) by adding at the end the following new subclauses:

“(IV) the Secretary provides notice of the waiver to the State long-term care ombudsman (established under section 307(a)(12) of the Older Americans Act of 1965) and the protection and advocacy system in the State for the mentally ill and the mentally retarded, and

“(V) the facility that is granted such a waiver notifies residents of the facility (or, where appropriate, the guardians or legal representatives of such residents) and members of their immediate families of the waiver.”.

(F) CLARIFICATION OF DEFINITION OF NURSE AIDE.—Section 1819(b)(5)(F)(i) (42 U.S.C. 1395i-3(b)(5)(F)(i)) is amended by striking “(G),” and inserting “(G)) or a registered dietitian,”.

(G) RESIDENTS’ RIGHTS TO REFUSE INTRA-FACILITY TRANSFERS FOR NON-MEDICAL REASONS.—Section 1819(c)(1)(A) (42 U.S.C. 1395i-3(c)(1)(A)) is amended—

- (i) by redesignating clause (x) as clause (xi) and by inserting after clause (ix) the following new clause:

“(x) REFUSAL OF CERTAIN TRANSFERS.—The right to refuse a transfer to another room within the facility, if a purpose of the transfer is to relocate the resident from a portion of the facility that is a skilled nursing facility (for purposes of this title) to a portion of the facility that is not such a skilled nursing facility.”; and

- (B) by adding at the end the following: “A resident’s exercise of a right to refuse transfer under clause (x) shall not affect the resident’s eligibility or entitlement to benefits under this title or to medical assistance under title XIX of this Act.”.

(H) RESIDENT ACCESS TO CLINICAL RECORDS.—Section 1819(c)(1)(A)(iv) (42 U.S.C. 1395i-3(c)(1)(A)(iv)) is amended by inserting before the period at the end the following: “and to access to current clinical records of the resident upon request by the resident or the resident’s legal representative, within 24 hours (excluding hours occurring during a weekend or holiday) after making such a request”.

(I) INCLUSION OF STATE NOTICE OF RIGHTS IN FACILITY NOTICE OF RIGHTS.—Section 1819(c)(1)(B)(ii) (42 U.S.C. 1395i-3(c)(1)(B)(ii)) is amended by inserting “including the notice (if any) of the State developed under section 1919(e)(6)” after “in such rights”.

(J) SPECIFICATION OF REQUIRED PROGRAMS.—Section 1819(e)(1)(A) (42 U.S.C. 1395i-3(e)(1)(A)) is amended by striking “clause (i) or (ii) of subsection (f)(2)(A)” and inserting “subsection (f)(2)”.

(K) CLARIFICATION OF NURSE AIDE REGISTRY REQUIREMENTS.—Section 1819(e)(2) (42 U.S.C. 1395i-3(e)(2)) is amended—

(i) in subparagraph (A), by striking the period and inserting the following: “, or any individual described in subsection (f)(2)(B)(ii) or in subparagraph (B), (C), or (D) of section 6901(b)(4) of the Omnibus Budget Reconciliation Act of 1989.”; and

(ii) by adding at the end the following new subparagraph:

“(C) PROHIBITION AGAINST CHARGES.—A State may not impose any charges on a nurse aide relating to the registry established and maintained under subparagraph (A).”.

(L) CLARIFICATION ON FINDINGS OF NEGLECT.—Section 1819(g)(1)(C) (42 U.S.C. 1395i-3(g)(1)(C)) is amended by adding at the end the following: “A State shall not make a finding that an individual has neglected a resident if the individual demonstrates that such neglect was caused by factors beyond the control of the individual.”.

(M) TIMING OF PUBLIC DISCLOSURE OF SURVEY RESULTS.—Section 1819(g)(5)(A)(i) (42 U.S.C. 1395i-3(g)(5)(A)(i)) is amended by striking “deficiencies and plans” and inserting “deficiencies, within 14 calendar days after such information is made available to those facilities, and approved plans”.

(N) OMBUDSMAN PROGRAM COORDINATION WITH STATE SURVEY AND CERTIFICATION AGENCIES.—Section 1819(g)(5)(B) (42 U.S.C. 1395i-3(g)(5)(B)) is amended by striking “with respect” and inserting “or of any adverse action taken against a skilled nursing facility under paragraphs (1), (2), or (4) of subsection (h), with respect”.

(O) MAINTAINING REGULATORY STANDARDS FOR CERTAIN SERVICES.—Any regulations promulgated and applied by the Secretary of Health and Human Services after the date of the enactment of the Omnibus Budget Reconciliation Act of 1987 with respect to services described in clauses (ii), (iv), and (v) of section 1819(b)(4)(A) of the Social Security Act shall include requirements for providers of such services that are at least as strict as the requirements applicable to providers of such services prior to the enactment of the Omnibus Budget Reconciliation Act of 1987.

(P) EFFECTIVE DATES.—The amendments made by this paragraph shall take effect as if they were included in the enactment of the Omnibus Budget Reconciliation Act of 1987.

(i) CLARIFICATION OF SECRETARIAL WAIVER AUTHORITY.—

(1) RURAL HOSPITAL DEMONSTRATION.—The Secretary of Health and Human Services is authorized to waive such provisions of title XVIII of the Social Security Act as are necessary to conduct any demonstration project for limited-service rural hospitals with respect to which the Secretary has entered into an agreement before the date of the enactment of the Omnibus Budget Reconciliation Act of 1989.

(2) NURSING HOME DEMONSTRATIONS.—Section 6901(d)(3)(B) of the Omnibus Budget Reconciliation Act of 1989 is amended—

(A) by striking “Wisconsin” and inserting “Wisconsin and nursing home case-mix demonstration projects in other States”; and

(B) by striking the second sentence.

42 USC 1395i-3
note.

42 USC 1395i-3
note.

42 USC 1395b-1
note.

(3) STATE WAIVER AUTHORITY.—Section 1814(b) (42 U.S.C. 1395f(b)) is amended—

(A) in paragraph (3)(B), by striking “October 1, 1983” and inserting “January 1, 1981”;

(B) in the second sentence, by striking “seventh month” and inserting “37th month”; and

(C) by adding at the end the following: “If, by the end of such 36-month period, the Secretary determines, based on evidence submitted by the Governor of the State, that neither of the conditions described in subparagraph (A) or (B) of paragraph (3) continues to apply, the Secretary shall continue without interruption payment to hospitals in the State under the State’s system. If, by the end of such 36-month period, the Secretary determines, based on such evidence, that either of the conditions described in subparagraph (A) or (B) of such paragraph continues to apply, the Secretary shall (i) collect any net excess reimbursement to hospitals in the State during such 36-month period (basing such net excess reimbursement on the net difference, if any, in the rate of increase in costs per hospital inpatient admission under the State system compared to the rate of increase in such costs with respect to all hospitals in the United States over the 36-month period, as measured by including the cumulative savings under the State system based on the difference in the rate of increase in costs per hospital inpatient admission under the State system as compared to the rate of increase in such costs with respect to all hospitals in the United States between January 1, 1981, and the date of the Secretary’s initial notice), and (ii) provide a reasonable period, not to exceed 2 years, for transition from the State system to the national payment system.”

(4) EFFECTIVE DATE.—The amendment made by paragraphs (1) and (2) shall be effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1989.

(j) DETERMINATION OF REASONABLE COSTS RELATING TO SWING BEDS.—

(1) IN GENERAL.—Section 1883(a)(2)(B)(ii)(II) (42 U.S.C. 1395tt(a)(2)(B)(ii)(II)) is amended by striking “the previous calendar year” and all that follows through the period and inserting “the most recent year for which cost reporting data are available with respect to such services (increased in a compounded manner by the applicable increase for payments for routine service costs of skilled nursing facilities under section 1888 for subsequent cost reporting periods and up to and including such calendar year) under this title to freestanding skilled nursing facilities in the region (as defined in section 1886(d)(2)(D)) in which the facility is located.”

(2) HOLD HARMLESS.—If, as a result of the amendment made by paragraph (1), the reasonable cost of routine services furnished by a hospital during a calendar year (as determined under section 1883 of the Social Security Act) is less than the reasonable cost of such services determined under such section for the previous calendar year, the reasonable cost of such services furnished by the hospital during the calendar year under such section shall be equal to the reasonable cost determined under such section for the previous calendar year.

42 USC 1395tt
note.

42 USC 1395tt
note.

(3) SWING BEDS CERTIFIED PRIOR TO MAY 1, 1987.—Notwithstanding the requirement of section 1883(b)(1) of the Social Security Act that the Secretary may not enter into an agreement under such section with a hospital that is not located in a rural area, any agreement entered into under such section on or before May 1, 1987, between the Secretary of Health and Human Services and a hospital located in an urban area shall remain in effect.

42 USC 1395tt
note.

(4) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to services furnished on or after October 1, 1990.

42 USC 1395yy
note.

(k) PROSPECTIVE PAYMENT SYSTEM FOR SKILLED NURSING FACILITY SERVICES.—

(1) DEVELOPMENT OF PROPOSAL.—The Secretary of Health and Human Services shall develop a proposal to modify the current system under which skilled nursing facilities receive payment for extended care services under part A of the medicare program or a proposal to replace such system with a system under which such payments would be made on the basis of prospectively determined rates. In developing any proposal under this paragraph to replace the current system with a prospective payment system, the Secretary shall—

(A) take into consideration the need to provide for appropriate limits on increases in expenditures under the medicare program without jeopardizing access to extended care services for individuals unable to care for themselves;

(B) provide for adjustments to prospectively determined rates to account for changes in a facility's case mix, volume of cases, and the development of new technologies and standards of medical practice;

(C) take into consideration the need to increase the payment otherwise made under such system in the case of services provided to patients whose length of stay or costs of treatment greatly exceed the length of stay or cost of treatment provided for under the applicable prospectively determined payment rate;

(D) take into consideration the need to adjust payments under the system to take into account factors such as a disproportionate share of low-income patients, differences in wages and wage-related costs among facilities located in various geographic areas, and other factors the Secretary considers appropriate; and

(E) take into consideration the appropriateness of classifying patients and payments upon functional disability, cognitive impairment, and other patient characteristics.

(2) REPORTS.—(A) By not later than April 1, 1991, the Secretary (acting through the Administrator of the Health Care Financing Administration) shall submit any research studies to be used in developing the proposal under paragraph (1) to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives.

(B) By not later than September 1, 1991, the Secretary shall submit the proposal developed under paragraph (1) to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives.

(C) By not later than March 1, 1992, the Prospective Payment Assessment Commission shall submit an analysis of and comments on the proposal developed under paragraph (1) to the

Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives.

(l) REVIEW OF HOSPITAL REGULATIONS WITH RESPECT TO RURAL HOSPITALS.—

42 USC 1395ww
note.

(1) **IN GENERAL.**—The Secretary of Health and Human Services shall review the requirements applicable under title XVIII of the Social Security Act to determine which requirements could be made less administratively and economically burdensome (without diminishing the quality of care) for hospitals defined in section 1886(d)(1)(B) of such Act that are located in a rural area (as defined in section 1886(d)(2)(D) of such Act). Such review shall specifically include standards related to staffing requirements.

(2) **REPORT.**—The Secretary of Health and Human Services shall report to Congress by April 1, 1992, on the results of the review conducted under subsection (a), and include conclusions on which regulations, if any, should be modified with respect to hospitals described in subsection (a).

(m) MISCELLANEOUS TECHNICAL CORRECTIONS.—

(1) **APPLICATION OF PREENTITLEMENT PSYCHIATRIC HOSPITAL SERVICES TO LIMIT ON INPATIENT HOSPITAL SERVICES.**—Effective as if included in the enactment of the Medicare Catastrophic Coverage Repeal Act of 1989, section 101(b)(1)(B) is amended by inserting “(other than the limitation under section 1812(c) of such Act)” after “limitation”.

42 USC 1395e
note.

(2) PROVISIONS RELATING TO HOSPITALS.—

(A) Section 1886(d)(5)(D)(iii) (42 U.S.C. 1395ww(d)(5)(D)(iii)), as amended by section 6003(e)(1)(A)(iv) of Omnibus Budget Reconciliation Act of 1989 (in this subsection referred to as “OBRA-1989”), is amended by striking “The term” and inserting “For purposes of this title, the term”.

(B) Section 1820 of such Act (42 U.S.C. 1395i-4), as added by section 6003(g)(1)(A) of the Omnibus Budget Reconciliation Act of 1989, is amended—

(i) in subsection (d)(1), by striking “demonstration”;

(ii) in subsection (g)(1)(A)(ii), by striking “rural referral center” and inserting “regional referral center”;

and

(iii) in subsection (j), by inserting “and part C” after “this part”.

(C) Section 6003(g)(3)(C)(vii)(I) of the Omnibus Budget Reconciliation Act of 1989 is amended by striking “each place it appears”.

42 USC 1395l.

(D) Section 1835(c) of the Social Security Act (42 U.S.C. 1395n(c)) is amended—

(i) in the first sentence, by striking “a hospital” and inserting “a hospital or a rural primary care hospital”;

(ii) in the second sentence, by striking “1833(a)(2)” and inserting “1833(a)(2) (or, in the case of a rural primary care hospital, in accordance with section 1833(a)(6))”; and

(iii) by striking the third sentence.

(3) TECHNICAL CORRECTIONS RELATING TO OTHER PROVIDERS OF SERVICES.—

(A) Section 1814(i)(1)(C)(i) (42 U.S.C. 1395f(i)(1)(C)(i)), as amended by section 6005(a)(2) of the Omnibus Budget Rec-

conciliation Act of 1989, is amended by striking “during fiscal year 1990” and inserting “on or after January 1, 1990, and on or before September 30, 1990.”

(B) Section 6005(c) of the Omnibus Budget Reconciliation Act of 1989 is amended by striking “subsection (a)” and inserting “subsections (a) and (b)”.

(C) Section 1818A(d)(1) (42 U.S.C. 1395i-2a(d)(1)), as inserted by section 6012(a)(2) of the Omnibus Budget Reconciliation Act of 1989, is amended—

(i) in subparagraph (A), by inserting “for enrollment under this section” after “Premiums”, and

(ii) by striking subparagraph (C).

(D) Section 1818(g)(2)(B) (42 U.S.C. 1395i-2(g)(2)(B)), as added by section 6013(a) of the Omnibus Budget Reconciliation Act of 1989, is amended by striking “subsection (c)” and inserting “subsection (c)(6)”.

(F) Section 1819(f)(2)(A)(ii) (42 U.S.C. 1395i-3(f)(2)(A)(ii)) is amended by striking “and” at the end.

(G) Section 1866(a)(1)(F) (42 U.S.C. 1395cc(a)(1)(F)) is amended—

(i) in clause (i), by striking the comma at the end and inserting “),”, and

(ii) in clause (ii), by striking “(4)(A)” and inserting “(3)(A)” and by striking the semicolon at the end and inserting a comma.

PART 2—PROVISIONS RELATING TO PART B

Subpart A—Payment for Physicians’ Services

SEC. 4101. CERTAIN OVERVALUED PROCEDURES.

(a) PREVIOUSLY IDENTIFIED PROCEDURES.—Section 1842(b)(14) (42 U.S.C. 1395u(b)(14)) is amended—

(1) by inserting “(i)” after “(14)(A)”;

(2) by adding at the end of subparagraph (A) the following new clause:

“(ii) In determining the reasonable charge for a physicians’ service specified in subparagraph (C)(i) and furnished during 1991, the prevailing charge for such service shall be the prevailing charge otherwise recognized for such service for the period during 1990 beginning on April 1, reduced by the same amount as the amount of the reduction effected under this paragraph (as amended by the Omnibus Budget Reconciliation Act of 1990) for such service during such period.”

(b) UNSURVEYED SURGICAL AND TECHNICAL PROCEDURES.—(1) Section 1842(b) (42 U.S.C. 1395u(b)) is amended by adding at the end the following new paragraph:

“(16)(A) In determining the reasonable charge for all physicians’ services other than physicians’ services specified in subparagraph (B) furnished during 1991, the prevailing charge for a locality shall be 6.5 percent below the prevailing charges used in the locality under this part in 1990 after March 31.

“(B) For purposes of subparagraph (A), the physicians’ services specified in this subparagraph are as follows:

“(i) Radiology, anesthesia and physician pathology services, the technical components of diagnostic tests specified in para-

graph (17) and physicians' services specified in paragraph (14)(C)(i).

"(ii) Primary care services specified in subsection (i)(4), hospital inpatient medical services, consultations, other visits, preventive medicine visits, psychiatric services, emergency care facility services, and critical care services.

"(iii) Partial, simple and subcutaneous mastectomy; tendon sheath injections; small joint arthrocentesis; femoral fracture treatments; trochanteric fracture treatments; endotracheal intubation; thoracentesis; thoracostomy; lobectomy; aneurysm repair; enterectomy; colectomy; cholecystectomy; cystourethroscopy; transurethral fulguration; transurethral resection; sacral laminectomy; tympanoplasty with mastoidectomy; and ophthalmoscopy."

(2) In applying section 1842(b)(16) of the Social Security Act:

42 USC 1395u
note.

(A) The codes for the procedures specified in clause (ii) are as follows: Hospital inpatient medical services (HCPCS codes 90200 through 90292), consultations (HCPCS codes 90600 through 90654), other visits (HCPCS code 90699), preventive medicine visits (HCPCS codes 90750 through 90764), psychiatric services (HCPCS codes 90801 through 90862), emergency care facility services (HCPCS codes 99062 through 99065), and critical care services (HCPCS codes 99160 through 99174).

(B) The codes for the procedures specified in clause (iii) are as follows: Partial, simple and subcutaneous mastectomy (HCPCS codes 19160 and 19162); tendon sheath injections and small joint arthrocentesis (HCPCS codes 20550, 20600, 20605, and 20610); femoral fracture and trochanteric fracture treatments (HCPCS codes 27230, 27232, 27234, 27238, 27240, 27242, 27246, and 27248); endotracheal intubation (HCPCS code 31500); thoracentesis (HCPCS code 32000); thoracostomy (HCPCS codes 32020, 32035, and 32036); aneurysm repair (HCPCS codes 35111); cystourethroscopy (HCPCS code 52340); transurethral fulguration and resection (HCPCS codes 52606 and 52620); tympanoplasty with mastoidectomy (HCPCS code 69645); and ophthalmoscopy (HCPCS codes 92250, and 92260)."⁵

SEC. 4102. RADIOLOGY SERVICES.

(a) **REDUCTION IN FEE SCHEDULE.**—Section 1834(b)(4) (42 U.S.C. 1395m(b)(4)) is amended—

(1) by redesignating subparagraphs (D) and (E) as subparagraphs (E) and (F), respectively, and

(2) by inserting after subparagraph (C) the following new subparagraph:

"(D) **1991 FEE SCHEDULES.**—For radiologist services (other than portable X-ray services) furnished under this part during 1991, the conversion factors used in a locality under this subsection shall be determined as follows:

"(i) **NATIONAL WEIGHTED AVERAGE CONVERSION FACTOR.**—The Secretary shall estimate the national weighted average of the conversion factors used under this subsection for services furnished during 1990 beginning on April 1, using the best available data.

"(ii) **REDUCED NATIONAL WEIGHTED AVERAGE.**—The national weighted average estimated under clause (i) shall be reduced by 13 percent.

⁵ So in original. The " " should probably be deleted.

“(iii) COMPUTATION OF 1990 LOCALITY INDEX RELATIVE TO NATIONAL AVERAGE.—The Secretary shall establish an index which reflects, for each locality, the ratio of the conversion factor used in the locality under this subsection to the national weighted average estimated under clause (i).

“(iv) LOCAL ADJUSTMENT.—Subject to clause (vii), the conversion factor to be applied to the professional or technical component of a service in a locality is the sum of $\frac{1}{2}$ of the locally-adjusted amount determined under clause (v) and $\frac{1}{2}$ of the GPCI-adjusted amount determined under clauses (vi).

“(v) LOCALLY-ADJUSTED AMOUNT.—For purposes of clause (iv), the locally adjusted amount determined under this clause is the product of (I) the national weighted average conversion factor computed under clause (ii), and (II) the index value established under clause (iii) for the locality.

“(vi) GPCI-ADJUSTED AMOUNT.—For purposes of clause (iv), the GPCI-adjusted amount determined under this clause is the sum of—

“(I) the product of (a) the portion of the reduced national weighted average conversion factor computed under clause (ii) which is attributable to physician work and (b) the geographic work index value for the locality (specified in Addendum C to the Model Fee Schedule for Physician Services (published on September 4, 1990, 55 Federal Register pp. 36238-36243)); and

“(II) the product of (a) the remaining portion of the reduced national weighted average conversion factor computed under clause (ii), and (b) the geographic practice cost index value specified in section 1842(b)(14)(C)(iv) for the locality.

In applying this clause with respect to the professional component of a service, 80 percent of the conversion factor shall be considered to be attributable to physician work and with respect to the technical component of the service, 0 percent shall be considered to be attributable to physician work.

“(vii) LIMITS ON CONVERSION FACTOR.—The conversion factor to be applied to a locality under this subparagraph to the professional or technical component of a service shall not be more than 9.5 percent below the conversion factor applied in the locality under subparagraph (C) to such component, but in no case shall the conversion factor be less than 60 percent of the national weighted average of the conversion factors (computed under clause (i)).”

(b) SPECIAL RULE FOR TRANSITION FOR RADIOLOGY SERVICES.—Section 1848(a)(2)(C) (42 U.S.C. 1395w-4(a)(2)(C)) is amended—

(1) by inserting “AND RADIOLOGY” after “SPECIAL RULE FOR ANESTHESIA”, and

(2) by adding at the end the following: “With respect to radiology services, ‘109 percent’ and ‘9 percent’ shall be substituted for ‘115 percent’ and ‘15 percent’, respectively, in subparagraph (A)(ii).

(c) **REDUCTION IN PREVAILING CHARGE LEVEL FOR OTHER RADIOLOGY SERVICES.**— 42 USC 1395m note.

(1) **IN GENERAL.**—In applying part B of title XVIII of the Social Security Act, the prevailing charge for physicians' services, furnished during 1991, which are radiology services may not exceed the fee schedule amount established under section 1834(b) of such Act with respect to such services.

(2) **EXCEPTION.**—Paragraph (1) shall not apply to radiology services which are subject to section 6105(b) of the Omnibus Budget Reconciliation Act of 1989.

(d) **REDUCTION IN PAYMENTS FOR TECHNICAL COMPONENTS OF CERTAIN SCANNING SERVICES.**—Section 1834(b)(4) (42 U.S.C. 1395m(b)(4)) is amended by inserting after subparagraph (D) the following new paragraph:

“(E) In the case of the technical components of magnetic resonance imaging (MRI) services and computer assisted tomography (CAT) services furnished after December 31, 1990, the amount otherwise payable shall be reduced by 10 percent.”.

(e) **LIMITATION ON ADJUSTMENTS.**—For radiologist services furnished during 1991 for which payment is made under section 1834(b) of the Social Security Act— 42 USC 1395m note.

(1) a carrier may not make any adjustment, under section 1842(b)(3)(B) of such Act, in the payment amount for the service under section 1834(b) on the basis that the payment amount is higher than the charge applicable, for a comparable service and under comparable circumstances, to the policyholders and subscribers of the carrier,

(2) no payment adjustment may be made under section 1842(b)(8) of such Act, and

(3) section 1842(b)(9) of such Act shall not apply.

(f) **USE OF LOCALITIES.**—Section 1834(b)(1)(B) (42 U.S.C. 1395m(b)(1)(B)) is amended by inserting “locality,” after “state-wide,”.

(g) **TREATMENT OF NUCLEAR MEDICINE PHYSICIANS.**—

(1) **CONTINUATION OF SPECIAL RULE.**—Section 6105(b) of the Omnibus Budget Reconciliation Act of 1989 is amended by striking all that follows “Social Security Act” the second place it appears and inserting the following: “beginning April 1, 1990, and ending December 31, 1991, there shall be substituted for the fee schedule otherwise applicable a fee schedule based $\frac{1}{3}$ on the fee schedule computed under such section (without regard to this subsection) and $\frac{2}{3}$ on 101 percent of the 1988 prevailing charge for such services.” 42 USC 1395m note.

(2) **ADJUSTED HISTORICAL PAYMENT BASIS.**—Section 1848(a)(2)(D) (42 U.S.C. 1395w-4(a)(2)(D)) is amended—

(A) in clause (ii) by inserting “, but excluding nuclear medicine services that are subject to section 6105(b) of the Omnibus Budget Reconciliation Act of 1989” after “section 1834(b)(6))”, and

(B) by adding at the end the following:

“(iii) **NUCLEAR MEDICINE SERVICES.**—In applying clause (i) in the case of physicians' services which are nuclear medicine services that are subject to section 6105(b) of the Omnibus Budget Reconciliation Act of 1989, there shall be substituted for the weighted aver-

age prevailing charge the amount provided under such section.”.

(h) **EXTENSION OF SPLIT BILLING RULE FOR INTERVENTIONAL RADIOLOGISTS.**—Section 6105(c) of the Omnibus Budget Reconciliation Act of 1989 is amended by inserting “or 1991” after “1990” each place it appears.

42 USC 1395m
note.

42 USC 1395m
note.

(i) **EFFECTIVE DATES.**—

(1) Except as otherwise provided, the amendments made by this section shall apply to services furnished on or after January 1, 1991.

(2) The amendment made by subsection (f) shall be effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1987.

SEC. 4103. ANESTHESIA SERVICES.

(a) **REDUCTION IN FEE SCHEDULE.**—Section 1842(q)(1) (42 U.S.C. 1395u(q)(1)) is amended—

(1) by inserting “(A)” after “(q)(1)”, and

(2) by adding at the end the following new subparagraph:

“(B) For physician anesthesia services furnished under this part during 1991, the prevailing charge conversion factor used in a locality under this subsection shall be determined as follows:

“(i) The Secretary shall estimate the national weighted average of the prevailing charge conversion factors used under this subsection for services furnished during 1990 after March 31, using the best available data.

“(ii) The national weighted average estimated under clause (i) shall be reduced by 7 percent.

“(iii) Subject to clause (iv), the prevailing charge conversion factor to be applied in a locality is the sum of—

“(I) the product of (a) the portion of the reduced national weighted average prevailing charge conversion factor computed under clause (ii) which is attributable to physician work and (b) the geographic work index value for the locality (specified in Addendum C to the Model Fee Schedule for Physician Services (published on September 4, 1990, 55 Federal Register pp. 36238-36243)); and

“(II) the product of (a) the remaining portion of the reduced national weighted average prevailing charge conversion factor computed under clause (ii) and (b) the geographic practice cost index value specified in section 1842(b)(14)(C)(iv) for the locality.

In applying this clause, 70 percent of the prevailing charge conversion factor shall be considered to be attributable to physician work.

“(iv) The prevailing charge conversion factor to be applied to a locality under this subparagraph shall not be reduced by more than 15 percent below the prevailing charge conversion factor applied in the locality for the period during 1990 after March 31, but in no case shall the prevailing charge conversion factor be less than 60 percent of the national weighted average of the prevailing charge conversion factors (computed under clause (i)).”.

(b) **EXTENSION OF REDUCTION FOR SUPERVISION OF CONCURRENT SERVICES.**—Section 1842(b)(13) (42 U.S.C. 1395u(b)(13)) is amended by striking “1991” each place it appears and inserting “1996”.

SEC. 4104. PHYSICIAN PATHOLOGY SERVICES.

(a) REDUCTION IN PAYMENTS FOR PHYSICIAN PATHOLOGY SERVICES.—Subsection (f) of section 1834 (42 U.S.C. 1395m) is amended to read as follows:

“(f) REDUCTION IN PAYMENTS FOR PHYSICIAN PATHOLOGY SERVICES DURING FISCAL YEAR 1991.—

“(1) IN GENERAL.—For physician pathology services furnished under this part during 1991, the prevailing charges used in a locality under this part shall be 7 percent below the prevailing charges used in the locality under this part in 1990 after March 31.

“(2) LIMITATION.—The prevailing charge for the technical and professional components of an physician pathology service furnished by a physician through an independent laboratory shall not be reduced pursuant to paragraph (1) to the extent that such reduction would reduce such prevailing charge below 115 percent of the prevailing charge for the professional component of such service when furnished by a hospital-based physician in the same locality. For purposes of the preceding sentence, an independent laboratory is a laboratory that is independent of a hospital and separate from the attending or consulting physicians’ office.”.

(b) CONFORMING AMENDMENTS.—

(1) Section 1833(a)(1)(J) of such Act (42 U.S.C. 1395l(a)(1)) is amended by striking “or physician pathology services” and by striking “or section 1834(f), respectively”.

(2) Section 1848(a)(1) of such Act (42 U.S.C. 1395w-4(a)(1)) is amended by striking “or 1834(f)”.

(3) Section 4050 of the Omnibus Budget Reconciliation Act of 1987 is repealed.

(c) ANCILLARY POLICY.—The Secretary of Health and Human Services, in establishing ancillary policies under section 1848(c)(3) of the Social Security Act, shall consider an appropriate adjustment to reflect the technical component of furnishing physician pathology services through a laboratory that is independent of a hospital and separate from an attending or consulting physician’s office.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 1991.

42 USC 1395l

note.

42 USC 1395w-4

note.

42 USC 1395l

note.

SEC. 4105. UPDATE FOR PHYSICIANS’ SERVICES.

(a) PERCENTAGE INCREASE IN MEI FOR 1991.—

(1) IN GENERAL.—Section 1842(b)(4)(E) (42 U.S.C. 1395u(b)(4)(E)) is amended by adding at the end the following new clause:

“(v) For purposes of this part for items and services furnished in 1991, the percentage increase in the MEI is—

“(I) 0 percent for services (other than primary care services), and

“(II) 2 percent for primary care services (as defined in subsection (i)(4)).”.

(2) CUSTOMARY CHARGES FOR 1991.—Section 1842(b)(4)(B) (42 U.S.C. 1395u(b)(4)(B)) is amended by adding at the end the following new clause:

“(iv) In determining the reasonable charge under paragraph (3) for physicians’ services (other than primary care services, as defined in subsection (i)(4)) furnished during 1991, the customary charges shall be the same customary charges as were recognized under this

section for the 9-month period beginning April 1, 1990. In a case in which subparagraph (F) applies (relating to new physicians) so as to limit the customary charges of a physician during 1990 to a percent of prevailing charges, the previous sentence shall not prevent such limit on customary charges under such subparagraph from increasing in 1991 to a higher percent of such prevailing charges.”.

(3) CHANGE IN PAYMENT FOR YEARS AFTER 1991.—Section 1848 of such Act (42 U.S.C. 1395w-4) is amended in subsection (d)(3)(A)—

(A) in clause (i), by inserting “except as provided in clause (iii),” after “subparagraph (B),”, and

(B) by adding at the end the following new clause:

“(iii) ADJUSTMENT IN PERCENTAGE INCREASE.—In applying clause (i) for services furnished in 1992 for which the appropriate update index is the index described in clause (ii)(I), the percentage increase in the appropriate update index shall be reduced by 0.4 percentage points.”.

(b) INCREASE IN PREVAILING CHARGE FLOOR FOR PRIMARY CARE SERVICES.—

(1) IN GENERAL.—Section 1842(b)(4)(A)(vi) of such Act (42 U.S.C. 1395u(b)(4)(A)(vi)) is amended by striking “50 percent” and inserting “60 percent”.

(2) BUDGET NEUTRAL IMPLEMENTATION.—In computing the conversion factor under section 1848(d)(1)(B) of the Social Security Act for 1992, the Secretary of Health and Human Services shall determine the estimated aggregate amount of payments under part B of title XVIII of such Act for physicians’ services in 1991 assuming that the amendments made by this subsection did not apply.

(3) EFFECTIVE DATE.—The amendments made by paragraphs (1) and (2) shall apply to services furnished on or after January 1, 1991.

(c) VOLUME PERFORMANCE STANDARD FOR FISCAL YEAR 1991.—Section 1848(f) (42 U.S.C. 1395w-4(f)) is amended—

(1) in paragraph (1)(C), by striking “1990” the first place it appears and inserting “1991”, and

(2) by adding at the end of paragraph (2) the following:

“(C) Notwithstanding subparagraph (A), the performance standard rate of increase for a category of physicians’ services for fiscal year 1991 shall be the sum of—

“(i) the Secretary’s estimate of the percentage by which actual expenditures for the category of physicians’ services under this part for fiscal year 1991 exceed actual expenditures for such category of services in fiscal year 1990 (determined without regard to the amendments made by the Omnibus Budget Reconciliation Act of 1990), and

“(ii) the Secretary’s estimate of the percentage increase or decrease in expenditures for the category of services in fiscal year 1991 (compared with fiscal year 1990) that will result from changes in law and regulations (including the Omnibus Budget Reconciliation Act of 1990), reduced by 2 percentage points.”

(d) Not later than 45 days after the date of the enactment of this Act, the Secretary of Health and Human Services, based on the most recent data available, shall estimate and publish in the Federal

42 USC 1395w-4
note.

42 USC 1395u
note.

42 USC 1395w-4
note.

Register the performance standard rates of increase specified in section 1848(f)(2)(C) of the Social Security Act for fiscal year 1991.

SEC. 4106. NEW PHYSICIANS AND OTHER NEW HEALTH CARE PRACTITIONERS.

(a) EXTENSION OF CUSTOMARY CHARGE LIMIT AND INCLUSION OF HEALTH CARE PRACTITIONERS.—

(1) **IN GENERAL.**—Subparagraph (F) of section 1842(b)(4) (42 U.S.C. 1395u(b)(4)) is amended to read as follows:

“(F)(i) In the case of physicians’ services and professional services of a health care practitioner (other than primary care services and other than services furnished in a rural area (as defined in section 1886(d)(2)(D)) that is designated, under section 332(a)(1)(A) of the Public Health Service Act, as a health manpower shortage area) furnished during the physician’s or practitioner’s first through fourth years of practice (if payment for those services is made separately under this part and on other than a cost-related basis), the prevailing charge or fee schedule amount to be applied under this part shall be 80 percent for the first year of practice, 85 percent for the second year of practice, 90 percent for the third year of practice, and 95 percent for the fourth year of practice, of the prevailing charge or fee schedule amount for that service under the other provisions of this part.

“(ii) For purposes of clause (i):

“(I) The term ‘health care practitioner’ means a physician assistant, certified nurse-midwife, qualified psychologist, nurse practitioner, clinical social worker, physical therapist, occupational therapist, respiratory therapist, certified registered nurse anesthetist, or any other practitioner as may be specified by the Secretary.

“(II) The term ‘first year of practice’ means, with respect to a physician or practitioner, the first calendar year during the first 6 months of which the physician or practitioner furnishes professional services for which payment is made under this part, and includes any period before such year.

“(III) The terms ‘second year of practice’, ‘third year of practice’, and ‘fourth year of practice’ mean the second, third, and fourth calendar years, respectively, following the first year of practice.”.

(2) **CONFORMING AMENDMENTS.**—Section 6108(a)(2)(A) of the Omnibus Budget Reconciliation Act of 1989 is amended—

(A) by inserting “or 1991” after “1990”, and

(B) by inserting “or 1990” after “1989”.

42 USC 1395u
note.

(b) APPLICATION UNDER FEE SCHEDULE.—

(1) **IN GENERAL.**—Section 1848(a) (42 U.S.C. 1395w-4(a)) is amended by adding at the end the following new paragraph:

“(4) **TREATMENT OF NEW PHYSICIANS.**—In the case of physicians’ services furnished by a physician before the end of the physician’s first full calendar year of furnishing services for which payment may be made under this part, and during each of the 3 succeeding years, the fee schedule amount to be applied shall be 80 percent, 85 percent, 90 percent, and 95 percent, respectively, of the fee schedule amount applicable to physicians who are not subject to this paragraph. The preceding sentence shall not apply to primary care services or services furnished in a rural area (as defined in section 1886(d)(2)) that is

designated under section 322(a)(1)(A) of the Public Health Service Act as a health manpower shortage area.”.

42 USC 1395u.

(2) CONFORMING AMENDMENTS.—Section 1842(b)(4)(F), as amended by subsection (a), is amended—

(A) in clause (i), by striking “physicians’ services and”,

(B) in clause (i), by striking “physician’s or”, and

(C) in clause (ii)(II), by striking “physician or” each place it appears.

42 USC 1395w-4
note.

(c) CONFORMING ADJUSTMENT IN CONVERSION FACTOR COMPUTATION.—In computing the conversion factor under section 1848(d)(1)(B) for 1992, the Secretary of Health and Human Services shall determine the estimated aggregate amount of payments under part B for physicians’ services in 1991 assuming that the amendments made by this section (notwithstanding subsection (d)) applied to all services furnished during such year.

42 USC 1395u
note.

(d) EFFECTIVE DATES.—

(1) The amendments made by subsection (a) apply to services furnished after 1990, except that—

(A) the provisions concerning the third and fourth years of practice apply only to physicians’ services furnished after 1990 and 1991, respectively, and

(B) the provisions concerning the second, third, and fourth years of practice apply only to services of a health care practitioner furnished after 1991, 1992, and 1993, respectively.

(2) The amendments made by subsection (b) shall apply to services furnished after 1991.

SEC. 4107. ASSISTANTS AT SURGERY.

(a) PHYSICIANS AS ASSISTANTS-AT-SURGERY.—

(1) IN GENERAL.—Section 1848(i) (42 U.S.C. 1395w-4(i)) is amended by adding at the end the following:

“(2) ASSISTANTS-AT-SURGERY.—

“(A) IN GENERAL.—Subject to subparagraph (B), in the case of a surgical service furnished by a physician, if payment is made separately under this part for the services of a physician serving as an assistant-at-surgery, the fee schedule amount shall not exceed 16 percent of the fee schedule amount otherwise determined under this section for the global surgical service involved.

“(B) DENIAL OF PAYMENT IN CERTAIN CASES.—If the Secretary determines, based on the most recent data available, that for a surgical procedure (or class of surgical procedures) the national average percentage of such procedure performed under this part which involve the use of a physician as an assistant at surgery is less than 5 percent, no payment may be made under this part for services of an assistant at surgery involved in the procedure.”.

42 USC 1395w-4
note.

(2) APPLICATION IN 1991.—Section 1848(i)(2) of the Social Security Act, as added by the amendment made by paragraph (1), shall apply to services furnished in 1991 in the same manner as it applies to services furnished after 1991. In applying the previous sentence, the prevailing charge shall be substituted for the fee schedule amount.

(b) CONFORMING AMENDMENT.—Section 1862(a)(15) of such Act (42 U.S.C. 1395y(a)(15)) is amended—

(1) by inserting “(A)” after “(15)”,

(2) by striking “; or” at the end and inserting “, or”, and

(3) by adding at the end the following new subparagraph:

“(B) which are for services of an assistant at surgery to which section 1848(i)(2)(B) applies; or”.

(c) **EFFECTIVE DATE.**—The amendment made by subsection shall apply with respect to services furnished on or after January 1, 1992. 42 USC 1395y note.

SEC. 4108. TECHNICAL COMPONENTS OF CERTAIN DIAGNOSTIC TESTS.

(a) **IN GENERAL.**—Section 1842(b) of the Social Security Act (42 U.S.C. 1395u(b)), as amended by section 4101, is further amended by adding at the end the following new paragraph:

“(18) With respect to payment under this part for the technical (as distinct from professional) component of diagnostic tests (other than clinical diagnostic laboratory tests and radiology services, including portable x-ray services) which the Secretary shall designate (based on their high volume of expenditures under this part), the reasonable charge for such technical component (including the applicable portion of a global service) may not exceed the national median of such charges for all localities, as estimated by the Secretary using the best available data.”.

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall apply to tests and services furnished on or after January 1, 1991. 42 USC 1395u note.

SEC. 4109. INTERPRETATION OF ELECTROCARDIOGRAMS.

(a) **IN GENERAL.**—Section 1848(b) of the Social Security Act (42 U.S.C. 1395w-4(b)) is amended by adding at the end the following new paragraph:

“(3) **TREATMENT OF INTERPRETATION OF ELECTROCARDIOGRAMS.**—If payment is made under this part for a visit to a physician or consultation with a physician and, as part of or in conjunction with the visit or consultation there is an electrocardiogram performed or ordered to be performed, no payment may be made under this part with respect to the interpretation of the electrocardiogram and no physician may bill an individual enrolled under this part separately for such an interpretation. If a physician knowingly and willfully bills one or more individuals in violation of the previous sentence, the Secretary may apply sanctions against the physician or entity in accordance with section 1842(j)(2).”.

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall apply to services furnished on or after January 1, 1992. In applying section 1848(d)(1)(B) of the Social Security Act (in computing the initial budget-neutral conversion factor for 1991), the Secretary shall compute such factor assuming that section 1848(b)(3) of such Act (as added by the amendment made by subsection (a)) had applied to physicians' services furnished during 1991. 42 USC 1395w-4 note.

SEC. 4110. RECIPROCAL BILLING ARRANGEMENTS.

(a) **IN GENERAL.**—The first sentence of section 1842(b)(6) of the Social Security Act (42 U.S.C. 1395u(b)(6)) is amended—

(1) by striking “and” before “(C)”, and

(2) by inserting before the period at the end the following: “, and (D) payment may be made to a physician who arranges for visit services (including emergency visits and related services) to be provided to an individual by a second physician on an occasional, reciprocal basis if (i) the first physician is unavail-

able to provide the visit services, (ii) the individual has arranged or seeks to receive the visit services from the first physician, (iii) the claim form submitted to the carrier includes the second physician's unique identifier (provided under the system established under subsection (r)) and indicates that the claim is for such a 'covered visit service (and related services)', and (iv) the visit services are not provided by the second physician over a continuous period of longer than 60 days".

42 USC 1395u
note.

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall apply to services furnished on or after the first day of the first month beginning more than 60 days after the date of the enactment of this Act.

42 USC 1395u
note.

SEC. 4111. STUDY OF PREPAYMENT MEDICAL REVIEW SCREENS.

(a) **IN GENERAL.**—The Secretary of Health and Human Services shall conduct a study of the effect of the release of medicare prepayment medical review screen parameters on physician billings for the services to which the parameters apply.

(b) **LIMITATIONS.**—The study shall be based upon the release of the screen parameters at a minimum of six carriers.

(c) **REPORT.**—The Secretary shall report the results of the study to the Committees on Ways and Means and Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate not later than October 1, 1992.

SEC. 4112. PRACTICING PHYSICIANS ADVISORY COUNCIL.

Title XVIII of the Social Security Act is amended by inserting after section 1867 the following new section:

"PRACTICING PHYSICIANS ADVISORY COUNCIL

42 USC 1395ee.

"SEC. 1868. (a) The Secretary shall appoint, based upon nominations submitted by medical organizations representing physicians, a Practicing Physicians Advisory Council (in this section referred to as the 'Council') to be composed of 15 physicians, each of whom has submitted at least 250 claims for physicians' services under this title in the previous year. At least 11 of the members of the Council shall be physicians described in section 1861(r)(1) and the members of the Council shall include both participating and nonparticipating physicians and physicians practicing in rural areas and underserved urban areas.

"(b) The Council shall meet once during each calendar quarter to discuss certain proposed changes in regulations and carrier manual instructions related to physician services identified by the Secretary. To the extent feasible and consistent with statutory deadlines, such consultation shall occur before the publication of such proposed changes.

"(c) Members of the Council shall be entitled to receive reimbursement of expenses and per diem in lieu of subsistence in the same manner as other members of advisory councils appointed by the Secretary are provided such reimbursement and per diem under this title."

42 USC 1395ff
note.

SEC. 4113. STUDY OF AGGREGATION RULE FOR CLAIMS FOR SIMILAR PHYSICIANS' SERVICES.

The Secretary of Health and Human Services shall carry out a study of the effects of permitting the aggregation of claims that involve common issues of law and fact furnished in the same carrier

area to two or more individuals by two or more physicians within the same 12-month period for purposes of appeals provided for under section 1869(b)(2). Such study shall be conducted in at least four carrier areas. The Secretary shall report on the results of such study and any recommendations to the Committee on Finance of the Senate and the Committees on Energy and Commerce and Ways and Means of the House of Representatives by December 31, 1992.

SEC. 4114. UTILIZATION SCREENS FOR PHYSICIAN VISITS IN REHABILITATION HOSPITALS.

42 USC 1395u
note.

Not later than 180 days after the date of the enactment of this Act, the Secretary of Health and Human Services shall issue guidelines to assure a uniform level of review of physician visits to patients of a rehabilitation hospital or unit patients after the medical review screen parameter established under section 4085(h) of the Omnibus Budget Reconciliation Act of 1987 has been exceeded.

SEC. 4115. STUDY OF REGIONAL VARIATIONS IN IMPACT OF MEDICARE PHYSICIAN PAYMENT REFORM.

42 USC 1395w-4
note.

(a) **STUDY.**—The Secretary of Health and Human Services shall conduct a study of—

(1) factors that may explain geographic variations in Medicare reasonable charges for physicians' services that are not attributable to variations in physician practice costs (including the supply of physicians in an area and area variations in the mix of services furnished);

(2) the extent to which the geographic practice cost indices applied under the fee schedule established under section 1848 of the Social Security Act accurately reflect variations in practice costs and malpractice costs (and alternative sources of information upon which to base such indices);

(3) the impact of the transition to a national, resource-based fee schedule for physicians' services under Medicare on access to physicians' services in areas that experience a disproportionately large reduction in payments for physicians' services under the fee schedule by reason of such variations; and

(4) appropriate adjustments or modifications in the transition to, or manner of determining payments under, the fee schedule established under section 1848 of the Social Security Act, to compensate for such variations and ensure continued access to physicians' services for Medicare beneficiaries in such areas.

(b) **REPORT.**—By not later than July 1, 1992, the Secretary shall submit to Congress a report on the study conducted under subsection (a).

SEC. 4116. LIMITATION ON BENEFICIARY LIABILITY.

Section 1848(g)(2)(A) (42 U.S.C. 1395w-4(g)(2)(A)) is amended by adding at the end thereof the following:

"In the case of evaluation and management services (as specified in section 1842(b)(16)(B)(ii)), the preceding sentence shall be applied by substituting '40 percent' for '25 percent'."

SEC. 4117. STATEWIDE FEE SCHEDULE AREAS FOR PHYSICIANS' SERVICES.

42 USC 1395w-4
note.

(a) **IN GENERAL.**—Notwithstanding section 1848(j)(2) of the Social Security Act (42 U.S.C. 1395w-4(j)(2)), in the case of the States of Nebraska and Oklahoma, if the respective State meets the require-

ments specified in subsection (b) on or before April 1, 1991, the Secretary of Health and Human Services (Secretary) shall treat the State as a single fee schedule area for purposes of determining—

(1) the adjusted historical payment basis (as defined in section 1848(a)(2)(D) of such Act (42 U.S.C. 1395w-4(a)(2)(D))), and

(2) the fee schedule amount (as referred to in section 1848(a) (42 U.S.C. 1395w-4(a)) of such Act),

for physicians' services (as defined in section 1848(j)(3) of such Act (42 U.S.C. 1395w-4(j)(3))) furnished on or after January 1, 1992.

(b) **REQUIREMENTS.**—The requirements specified in this subsection are that (on or before April 1, 1991) there are written expressions of support for treatment of the State as a single fee schedule area (on a budget-neutral basis) from—

(1) each member of the congressional delegation from the State, and

(2) organizations representing urban and rural physicians in the State.

(c) **BUDGET NEUTRALITY.**—Notwithstanding section 1842(b)(3) of such Act (42 U.S.C. 1395u(b)(3)), the Secretary shall provide for treatment of a State as a single fee schedule area (as described in subsection (a)) in a manner that ensures that total payments for physicians' services (as so defined) furnished by physicians in the State during 1992 are not greater or less than total payments for such services would have been but for such treatment.

(d) **CONSTRUCTION.**—Nothing in this section shall be construed as limiting the availability (to the Secretary, the appropriate agency or organization with a contract under section 1842, or physicians in a State) of otherwise applicable administrative procedures for modifying the fee schedule area or areas in the State after implementation of subsection (a) with respect to the State.

SEC. 4118. TECHNICAL CORRECTIONS.

(a) **OVERVALUED PROCEDURES.**—

(1) Section 1842(b)(14) of the Social Security Act (42 U.S.C. 1395u(b)(14)) is amended—

(A) in subparagraph (B)(iii)(I), by striking “practice expense ratio for the service (specified in table #1 in the Joint Explanatory Statement referred to in subparagraph (C)(i))” and inserting “practice expense component (percent), divided by 100, specified in appendix A (pages 187 through 194) of the Report of the Medicare and Medicaid Health Budget Reconciliation Amendments of 1989, prepared by the Subcommittee on Health and the Environment of the Committee on Energy and Commerce, House of Representatives, (Committee Print 101-M, 101st Congress, 1st Session) for the service”;

(B) in subparagraph (B)(iii)(II), by striking “practice expense ratio” and inserting “practice expense component (percent), divided by 100”;

(C) in subparagraph (C)(i), by striking “physicians' services specified in Table #2 in the Joint Explanatory Statement of the Committee of Conference submitted with the Conference Report to accompany H.R. 3299 (the ‘Omnibus Budget Reconciliation Act of 1989’), 101st Congress,” and inserting “procedures specified (by code and description) in the Overvalued Procedures List for Finance Committee,

Revised September 20, 1989, prepared by the Physician Payment Review Commission”;

(D) in subparagraph (C)(iii), by striking “The ‘percent change’ specified in this clause, for a physicians’ service specified in clause (i), is the percent change specified for the service in table #2 in the Joint Explanatory Statement” and inserting “The ‘percentage change’ specified in this clause, for a physicians’ service specified in clause (i), is the percent difference (but expressed as a positive number) specified for the service in the list”; and

(E) in subparagraph (C)(iv), by striking “such value specified for the locality in table #3 in the Joint Explanatory Statement referred to in clause (i)” and inserting “the Geographic Overhead Costs Index specified for the locality in table 1 of the September 1989 Supplement to the Geographic Medicare Economic Index: Alternative Approaches (prepared by the Urban Institute and the Center for Health Economics Research)”.

(2) Section 1842(b)(4)(E)(iv)(I) of such Act (42 U.S.C. 1395u(b)(4)(E)(iv)(I)) is amended by striking “Table #2” and all that follows through “101st Congress” and inserting “the list referred to in paragraph (14)(C)(i)”.

(3) The amendments made by paragraphs (1) and (2) apply to services furnished after March 1990.

42 USC 1395u
note.

(b) MVPS AS MULTIPLICATIVE, NOT ADDITIVE.—Section 1848(f)(2)(A) (42 U.S.C. 1395w-4(f)(2)(A)) is amended—

(1) in the matter preceding clause (i) by striking “sum” and inserting “product”;

(2) in clauses (i) through (iv), by inserting “1 plus” before “the Secretary’s” each place it appears,⁶

(3) in clause (i), by inserting “(divided by 100)” after “percentage increase”,⁷

(4) in clauses (ii) and (iv), by inserting “(divided by 100)” after “decrease”,⁸

(5) in clause (iii), by inserting “(divided by 100)” after “percentage growth”,⁹ and

(6) in the matter following clause (iv), by striking “reduced” and inserting “minus 1, multiplied by 100, and reduced”.

(c) PERIODIC REVIEW OF GEOGRAPHIC ADJUSTMENT FACTORS.—Section 1848(e)(1) of such Act is amended—

(1) in subparagraph (A), by striking “subparagraph (B)” and inserting “subparagraphs (B) and (C)”, and

(2) by adding at the end the following new subparagraph:

“(C) PERIODIC REVIEW AND ADJUSTMENTS IN GEOGRAPHIC ADJUSTMENT FACTORS.—The Secretary, not less often than every 3 years, shall review the indices established under subparagraph (A) and the geographic index values applied under this subsection for all fee schedule areas. Based on such review, the Secretary may revise such index and adjust such index values, except that, if more than 1 year has elapsed since the last previous adjustment, the adjustment to be applied in the first year of the next adjustment shall be ½ of the adjustment that otherwise would be made.”.

(d) ELIMINATION OF RESTRICTION ON INCORPORATION OF TIME IN VISIT CODES.—Section 1848(c)(4) (42 U.S.C. 1395w-4(c)(4)) is amended by striking “only for services furnished on or after January 1, 1993”

⁶ So in original. Probably should be “.”.

⁷ So in original. Probably should be “.”.

⁸ So in original. Probably should be “.”.

⁹ So in original. Probably should be “.”.

(e) **TREATMENT OF PRICE INCREASE IN DETERMINING PERFORMANCE STANDARD RATES OF INCREASE.**—Section 1848(f)(2)(A)(iv) (42 U.S.C. 1395w-4(f)(2)(A)(iv)) is amended by inserting “including changes in law and regulations affecting the percentage increase described in clause (i)” after “law or regulations”.

(f) **MISCELLANEOUS FEE SCHEDULE CORRECTIONS.**—

(1) **CHANGES IN SECTION 1848.**—Section 1848 of the Social Security Act (42 U.S.C. 1395w-4) is amended—

(A) in subsection (c)(1)(B), by striking the last sentence;

(B) in subsections (c)(3)(C)(ii)(II) and (c)(3)(C)(iii)(II), by striking “by” the first place it appears in each respective subsection,¹⁰

(C) in subsection (c), by redesignating the second paragraph (3), and paragraphs (4) and (5), as paragraphs (4) through (6), respectively;

(D) in subsection (c)(4), as redesignated by subparagraph (C), is amended by striking “subsection” and inserting “section”;

(E) in subsection (d)(1)(A), by striking “subparagraph (C)” and inserting “paragraph (3)”;

(F) in subsection (d)(1)—

(i) in subparagraph (A)—

(I) by inserting “(or factors)” after “conversion factor” each place it appears,

(II) by inserting “or updates” after “update”, and

(III) by striking “subparagraph (C)” and inserting “paragraph (3)”;

(ii) in subparagraph (C)—

(I) in clause (i), by striking “(or factors)”, and

(II) in clause (ii), by inserting “the conversion factor (or factors) which will apply to physicians’ services for the following year and” before “the update (or updates)”, and by striking “the following” and inserting “such”;

(G) in subsection (d)(2)(A), in the matter preceding clause (i), by striking “services” the first place it appears and inserting “services (as defined in subsection (f)(5)(A))”;

(H) in subsection (d)(2)(A)(ii)—

(i) by striking “(as defined in subsection (f)(5)(A))” and inserting “and for the services involved”, and

(ii) by striking “all such physicians” and inserting “such”; and

(I) in the last sentence of subsection (d)(2)(A), by striking “proportion of HMO enrollees” and inserting “proportion of individuals who are enrolled under this part who are HMO enrollees”;

(J) in subsection (d)(2)(E)(i), by inserting “the” after “as set forth in”;

(K) in subsection (d)(2)(E)(ii)(I), by inserting “payments for” after “under this part for”;

(L) in subsection (d)(3)(B)—

(i) in clause (i)—

(I) by striking “update for” and inserting “update for a category of physicians’ services for”; and

¹⁰ So in original. Probably should be “;”.

(II) by striking “physicians’ services (as defined in subsection (f)(5)(A))” and inserting “services in such category”;

(ii) in clause (ii)—

(I) by inserting “more than” after “decrease of”; and

(II) in subclause (I), by striking “more than”;

(M) in paragraphs (1)(D)(i) and (2)(A)(i) of subsection (f), by striking “calendar years” and inserting “portions of calendar years”;

(N) in subsection (f)(2)(A)—

(i) by striking “each performance standard rate of increase” and inserting “the performance standard rate of increase, for all physicians’ services and for each category of physicians’ services,”;

(ii) in clause (i), by striking “physicians’ services (as defined in subsection (f)(5)(A))¹¹” and inserting “all physicians’ services or for the category of physicians’ services, respectively,”;

(iii) in clause (iii), by striking “physicians’ services” and inserting “all physicians’ services or of the category of physicians’ services, respectively,”; and

(iv) in clause (iv), by striking “physicians’ services (as defined in subsection (f)(5)(A))” and inserting “all physicians’ services or of the category of physicians’ services, respectively,”;

(O) in subsection (f)(4)(A), by striking “paragraph (B)” and inserting “subparagraph (B)”;

(P) in subsection (f)(4)(B), by striking “Congress specifically approves the plan” and inserting “specifically approved by law”;

(Q) in subparagraphs (A) and (B) of subsection (g)(2), by inserting “other than radiologist services subject to section 1834(b),” after “during 1991,” and after “during 1992,” respectively;

(R) in subsection (i)(1)(A), by striking “historical payment basis (as defined in subsection (a)(2)(C)(i))” and inserting “adjusted historical payment basis (as defined in subsection (a)(2)(D)(i))”; and

(S) in subsection (j)(1), by striking “, and such other” and all that follows through the period and inserting “(as defined by the Secretary) and all other physicians’ services.”

(2) MISCELLANEOUS.—

(A) Effective as if included in the Omnibus Budget Reconciliation Act of 1989, section 6102(e)(4) of such Act is amended by inserting “determined” after “prevailing charge rate”. 42 USC 1395u.

(B) Effective January 1, 1991, section 1842(b)(3)(G) of the Social Security Act, as amended by section 6102(e)(2) of Omnibus Budget Reconciliation Act of 1989, is amended by striking “subsection (j)(1)(C)” and inserting “section 1848(g)(2)”. 42 USC 1395u.

(C) Section 1842(b)(12)(A)(ii)(II) of the Social Security Act, as amended by section 6102(e)(4) of the Omnibus Budget Reconciliation Act of 1989, is amended by striking “, as the case may be”.

¹¹ So in original. Probably should be “(A)”.

42 USC 1395l.

(D) Section 1833(a)(1)(H) of the Social Security Act, as amended by section 6102(e)(5) of the Omnibus Budget Reconciliation Act of 1989, is amended by striking “, as the case may be”.

42 USC 1395w-4
note.

(E) Section 6102(e)(11) of the Omnibus Budget Reconciliation Act of 1989 is amended by inserting “of Health and Human Services” after “Secretary”.

(F) Effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1989, section 922(d)(1) of the Public Health Service Act (42 U.S.C. 299c-1(d)(1)) is amended—

(i) by inserting “(other than of dissemination activities)” after “evaluations”, and

(ii) by inserting “research, demonstration projects, or evaluations of” after “applications with respect to”

(g) REPEAL OF REPORTS NO LONGER REQUIRED.—

(1) Subsection (b) of section 4043 of the Omnibus Budget Reconciliation Act of 1987 is repealed.

(2) Subsection (c) of section 4048 of such Act is repealed.

(3) Section 4049(b)(1) of such Act is amended by striking “, and shall report” and all that follows up to the period at the end.

(4) Section 4056(a)(1) of such Act, as redesignated by section 411(f)(14) of the Medicare Catastrophic Coverage Act of 1988, is amended by striking the last sentence.

(5) Section 4056(b)(2) of such Act is amended by striking the second sentence.

(h) ADJUSTMENT OF EFFECTIVE DATES.—Effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1987—

(1) section 4048(b) of such Act is amended by striking “January 1, 1989” and inserting “March 1, 1989”, and

(2) section 4049(b)(2) of such Act is amended by striking “January 1, 1989” and inserting “April 1, 1989”.

(i) TRANSFER OF PROVISION INTO TITLE XVIII.—

(1) Section 1842 of the Social Security Act (42 U.S.C. 1395u) is amended by adding at the end the following new subsection:
“(r) The Secretary shall establish a system which provides for a unique identifier for each physician who furnishes services for which payment may be made under this title.”.

(2) Section 9202 of the Consolidated Omnibus Budget Reconciliation Act of 1985 is amended by striking subsection (g).

(j) PPRC.—(1) Section 1845 of such Act (42 U.S.C. 1395w-1) is amended—

(A) in subsection (a)(3), by striking “include physicians” and inserting “include (but need not be limited to) physicians”;

(B) by striking subsection (b)(3);

(C) in subsection (b)(2)—

(i) by striking “and” at the end of subparagraph (H),

(ii) by striking the period at the end of subparagraph (I) and inserting a semicolon,

(iii) by striking subparagraphs (A), (B), (C), and (F),

(iv) by redesignating subparagraphs (D), (E), (G), (H), and (I) as subparagraphs (A), (B), (C), (D), and (E), and

(v) by adding at the end the following new subparagraphs:

“(F) make recommendations regarding major issues in the implementation of the resource-based relative value scale established under section 1848(c);

42 USC 1395l
note.

42 USC 1395u
note.

42 USC 1395m
note.

42 USC 1395u
note.

42 USC 1395w-1
note.

42 USC 1395u
note.

42 USC 1395m
note.

42 USC 1395ww
note.

“(G) make recommendations regarding further development of the volume performance standards established under section 1848(f), including the development of State-based programs;

“(H) consider policies to provide payment incentives to increase patient access to primary care and other physician services in large urban and rural areas, including policies regarding payments to physicians pursuant to title XIX;

“(I) review and consider the number and practice specialties of physicians in training and payments under this title for graduate medical education costs;

“(J) make recommendations regarding issues relating to utilization review and quality of care, including the effectiveness of peer review procedures and other quality assurance programs applicable to physicians and providers under this title and physician certification and licensing standards and procedures;

“(K) make recommendations regarding options to help constrain the costs of health insurance to employers, including incentives under this title;

“(L) comment on the recommendations affecting physician payment under the medicare program that are included in the budget submitted by the President pursuant to section 1105 of title 31, United States Code; and

“(M) make recommendations regarding medical malpractice liability reform and physician certification and licensing standards and procedures.”; and

(D) by striking subsection (e) and redesignating subsection (f) as subsection (e). 42 USC 1395w-1.

(2) In section 1842(b)(2)(A) is amended by striking “section 1845(f)(2)” and inserting “section 1845(e)(2)”. 42 USC 1395u.

(k) PROHIBITION OF CERTAIN ADJUSTMENTS.—Section 1848(i) is amended by adding at the end the following new paragraph: 42 USC 1395w-4.

“(3) NO COMPARABILITY ADJUSTMENT.—For physicians’ services for which payment under this part is determined under this section—

“(A) a carrier may not make any adjustment in the payment amount under section 1842(b)(3)(B) on the basis that the payment amount is higher than the charge applicable, for a ¹² comparable services and under comparable circumstances, to the policyholders and subscribers of the carrier,

“(B) no payment adjustment may be made under section 1842(b)(8), and

“(C) section 1842(b)(9) shall not apply .”

Subpart B—Provisions Relating to Other Items and Services

SEC. 4151. PAYMENTS FOR OUTPATIENT HOSPITAL SERVICES.

(a) REDUCTION IN PAYMENTS FOR CAPITAL-RELATED COSTS.—

(1) IN GENERAL.—Section 1861(v)(1)(S)(ii)(I) (42 U.S.C. 1395x(v)(1)(S)(ii)(I)) is amended by inserting before the period at the end the following: “, by 15 percent for payments attributable to portions of cost reporting periods occurring during fiscal year 1991, and by 10 percent for payments attributable to portions of cost reporting periods occurring during fiscal year 1992, 1993, 1994, or 1995”

¹² So in original. “a” probably should be omitted.

(2) **EXEMPTION FOR RURAL PRIMARY CARE HOSPITALS.**—Section 1861(v)(1)(S)(ii)(II) (42 U.S.C. 1395x(v)(1)(S)(ii)(II)) is amended by striking “1886(d)(5)(D)(iii).” and inserting “1886(d)(5)(D)(iii) or a rural primary care hospital (as defined in section 1861(mm)(1)).”

(b) **REDUCTION IN REASONABLE COSTS OF HOSPITAL OUTPATIENT SERVICES.**—

(1) **IN GENERAL.**—Section 1861(v)(1)(S)(ii) (42 U.S.C. 1395x(v)(1)(S)(ii)) is amended—

(A) in subclause (II)—

(i) by striking “Subclause (I)” and inserting “Subclauses (I) and (II)”, and

(ii) by striking “capital-related costs of any hospital” and inserting “costs of hospital outpatient services provided by any hospital”;

(B) in subclause (III)—

(i) by striking “subclause (I)” and inserting “subclauses (I) and (II)”, and

(ii) by striking “capital-related” and inserting “the”;

(C) by redesignating subclauses (II) and (III) as subclauses (III) and (IV); and

(D) by inserting after subclause (I) the following new subclause:

“(II) The Secretary shall reduce the reasonable cost of outpatient hospital services (other than the capital-related costs of such services) otherwise determined pursuant to section 1833(a)(2)(B)(i)(I) by 5.8 percent for payments attributable to portions of cost reporting periods occurring during fiscal years 1991, 1992, 1993, 1994, or 1995.”.

(2) **PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT SERVICES.**—

(A) **DEVELOPMENT OF PROPOSAL.**—The Secretary of Health and Human Services shall develop a proposal to replace the current system under which payment is made for hospital outpatient services under title XVIII of the Social Security Act with a system under which such payments would be made on the basis of prospectively determined rates. In developing any proposal under this paragraph, the Secretary shall consider—

(i) the need to provide for appropriate limits on increases in expenditures under the medicare program;

(ii) the need to adjust prospectively determined rates to account for changes in a hospital’s outpatient case mix, severity of illness of patients, volume of cases, and the development of new technologies and standards of medical practice;

(iii) providing hospitals with incentives to control the costs of providing outpatient services;

(iv) the feasibility and appropriateness of including payment for outpatient services not currently paid on a cost-related basis under the medicare program (including clinical diagnostic laboratory tests and dialysis services) in the system;

(v) the need to increase payments under the system to hospitals that treat a disproportionate share of low-income patients, teaching hospitals, and hospitals located in geographic areas with high wages and wage-related costs;

(vi) the feasibility and appropriateness of bundling services into larger units, such as episodes or visits, in establishing the basic unit for making payments under the system; and

(vii) the feasibility and appropriateness of varying payments under the system on the basis of whether services are provided in a free-standing or hospital-based facility.

(B) REPORTS.—(i) By not later than January 1, 1991, the Administrator of the Health Care Financing Administration shall submit research findings relating to prospective payments for hospital outpatient services to the Committee on Finance of the Senate and the Committees on Ways and Means and Energy and Commerce of the House of Representatives.

(ii) By not later than September 1, 1991, the Secretary shall submit the proposal developed under subparagraph (A) to such Committees.

(iii) By not later than March 1, 1992, the Prospective Payment Assessment Commission shall submit an analysis of and comments on the proposal developed under subparagraph (A) to such Committees.

(C) PAYMENTS FOR AMBULATORY SURGICAL PROCEDURES AND RADIOLOGY SERVICES.—

(1) MODIFICATION OF COST AND ASC PROPORTIONS OF ASC BLEND AMOUNTS.—

(A) IN GENERAL.—Section 1833(i)(3)(B)(ii) (42 U.S.C. 1395l(i)(3)(B)(ii)) is amended—

(i) in subclause (I), by striking “and 50 percent for other cost reporting periods.” and inserting “50 percent for reporting periods beginning on or after October 1, 1988, and on or before December 31, 1990, and 42 percent for portions of cost reporting periods beginning on or after January 1, 1991.”; and

(ii) in subclause (II), by striking “and 50 percent for other cost reporting periods.” and inserting “50 percent for reporting periods beginning on or after October 1, 1988, and on or before December 31, 1990, and 58 percent for portions of cost reporting periods beginning on or after January 1, 1991.”.

(B) EXTENSION OF ASC BLEND AMOUNTS FOR EYE AND EAR AND EAR SPECIALTY HOSPITALS.—The last sentence of section 1833(i)(3)(B)(ii) (42 U.S.C. 1395l(i)(3)(B)(ii)) is amended by striking “in fiscal year 1989 or fiscal year 1990” and inserting “on or after October 1, 1988, and before January 1, 1995”.

(2) MODIFICATION OF COST AND CHARGE PROPORTIONS FOR RADIOLOGY SERVICES.—Section 1833(n)(1)(B)(ii)(I) (42 U.S.C. 1395l(n)(1)(B)(ii)(I)) is amended by striking the period at the end and inserting “, and such term means 42 percent in the case of outpatient radiology services for portions of cost reporting periods beginning on or after January 1, 1991.”.

(3) 2-YEAR FREEZE IN ALLOWANCE FOR INTRAOCULAR LENSES.—Notwithstanding section 1833(i)(2)(A)(iii) of the Social Security Act, the amount of payment determined under such section for the insertion of an intraocular lens during or subsequent to cataract surgery furnished to an individual in an ambulatory

42 USC 1395l
note.

surgical center on or after the date of the enactment of this Act and on or before December 31, 1992, shall be equal to \$200.

SEC. 4152. DURABLE MEDICAL EQUIPMENT.

(a) PAYMENTS FOR SEAT-LIFT AND TENS.—

(1) **15 PERCENT REDUCTION IN PAYMENTS FOR TRANSCUTANEOUS ELECTRICAL NERVE STIMULATORS.**—Section 1834(a)(1)(D) of the Social Security Act (42 U.S.C. 1395m(a)(1)(D)) is amended by inserting before the period at the end the following: “, and, in the case of a transcutaneous electrical nerve stimulator furnished on or after January 1, 1991, the Secretary shall further reduce such payment amount (as previously reduced) by 15 percent”.

(2) **SEAT-LIFTS.**—Section 1861(n) of the Social Security Act (42 U.S.C. 1395x(n)) is amended by adding at the end the following: “With respect to a seat-lift chair, such term includes only the seat-lift mechanism and does not include the chair.”.

42 USC 1395m
note.

(3) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall apply to items furnished on or after January 1, 1991.

(b) DEVELOPMENT AND APPLICATION OF NATIONAL LIMITS ON FEES.—

(1) **INEXPENSIVE AND ROUTINELY PURCHASED DURABLE MEDICAL EQUIPMENT AND ITEMS REQUIRING FREQUENT AND SUBSTANTIAL SERVICING.**—Paragraphs (2) and (3) of section 1834(a) of such Act (42 U.S.C. 1395m(a)) are each amended—

(A) in subparagraph (B)(i), by striking “or” at the end;

(B) by striking clause (ii) of subparagraph (B) and inserting the following:

“(ii) in 1991 is the sum of (I) 67 percent of the local payment amount for the item or device computed under subparagraph (C)(i)(I) for 1991, and (II) 33 percent of the national limited payment amount for the item or device computed under subparagraph (C)(ii) for 1991;

“(iii) in 1992 is the sum of (I) 33 percent of the local payment amount for the item or device computed under subparagraph (C)(i)(II) for 1992, and (II) 67 percent of the national limited payment amount for the item or device computed under subparagraph (C)(ii) for 1992; and

“(iv) in 1993 and each subsequent year is the national limited payment amount for the item or device computed under subparagraph (C)(ii) for that year.”; and

(C) by adding at the end the following new subparagraph:

“(C) **COMPUTATION OF LOCAL PAYMENT AMOUNT AND NATIONAL LIMITED PAYMENT AMOUNT.**—For purposes of subparagraph (B)—

“(i) the local payment amount for an item or device for a year is equal to—

“(I) for 1991, the amount specified in subparagraph (B)(i) for 1990 increased by the covered item update for 1991, and

“(II) for 1992, the amount determined under this clause for the preceding year increased by the covered item update for 1992; and

“(ii) the national limited payment amount for an item or device for a year is equal to—

“(I) for 1991, the local payment amount determined under clause (i) for such item or device for that year, except that the national limited payment amount may not exceed 100 percent of the weighted average of all local payment amounts determined under such clause for such item for that year and may not be less than 85 percent of the weighted average of all local payment amounts determined under such clause for such item, and

“(II) for each subsequent year, the amount determined under this clause for the preceding year increased by the covered item update for such subsequent year.”.

(2) MISCELLANEOUS ITEMS AND OTHER COVERED ITEMS.—Section 1834(a)(8) (42 U.S.C. 1395m(a)(8)) is amended—

(A) in subparagraph (A)(ii)—

(i) by striking “or” at the end of subclause (I);

(ii) in subclause (II)—

(I) by striking “1991 or”, and

(II) by striking “the percentage increase” and all that follows through the period and inserting “the covered item update for the year.”;

(iii) by redesignating subclause (II) as subclause (III); and

(iv) by inserting after subclause (I) the following new subclause:

“(II) in 1991, equal to the local purchase price computed under this clause for the previous year, increased by the covered item update for 1991, and decreased by the percentage by which the average of the reasonable charges for claims paid for all items described in paragraph (7) is lower than the average of the purchase prices submitted for such items during the final 9 months of 1988; or”;

(B) by amending subparagraph (B) to read as follows:

“(B) COMPUTATION OF NATIONAL LIMITED PURCHASE PRICE.—With respect to the furnishing of a particular item in a year, the Secretary shall compute a national limited purchase price—

“(i) for 1991, equal to the local purchase price computed under subparagraph (A)(ii) for the item for the year, except that such national limited purchase price may not exceed 100 percent of the weighted average of all local purchase prices for the item computed under such subparagraph for the year, and may not be less than 85 percent of the weighted average of all local purchase prices for the item computed under such subparagraph for the year; and

“(ii) for each subsequent year, equal to the amount determined under this subparagraph for the preceding year increased by the covered item update for such subsequent year.”;

(C) in subparagraph (C)—

(i) by striking “regional purchase price” each place it appears and inserting “national limited purchase price”;

(ii) by striking “and subject to subparagraph (D)”,

(iii) in clause (ii)—

(I) by striking “75” and inserting “67”; and

(II) by striking “25” and inserting “33”, and

(iv) in clause (iii)—

(I) in subclause (I), by striking “50” and inserting “33” and by striking “(A)(ii)(II)” and inserting “(A)(ii)(III)”; and

(II) in subclause (II), by striking “50” and inserting “67”; and

(D) by striking subparagraph (D).

(3) OXYGEN AND OXYGEN EQUIPMENT.—Section 1834(a)(9) of such Act (42 U.S.C. 1395m(a)(9)) is amended—

(A) in subparagraph (A)(ii)(II), by striking “the percentage increase” and all that follows through the period and inserting “the covered item increase for the year.”;

(B) by amending subparagraph (B) to read as follows:

“(B) COMPUTATION OF NATIONAL LIMITED MONTHLY PAYMENT RATE.—With respect to the furnishing of an item in a year, the Secretary shall compute a national limited monthly payment rate equal to—

“(i) for 1991, the local monthly payment rate computed under subparagraph (A)(ii)(II) for the item for the year, except that such national limited monthly payment rate may not exceed 100 percent of the weighted average of all local monthly payment rates computed for the item under such subparagraph for the year, and may not be less than 85 percent of the weighted average of all local monthly payment rates computed for the item under such subparagraph for the year; and

“(ii) for each subsequent year, equal to the amount determined under this subparagraph for the preceding year increased by the covered item update for such subsequent year.”;

(C) in subparagraph (C)—

(i) by striking “regional monthly payment rate” each place it appears and inserting “national limited monthly payment rate”,

(ii) in clause (ii)—

(I) by striking “75” and inserting “67”; and

(II) by striking “25” and inserting “33”, and

(iii) in clause (iii)—

(I) in subclause (I), by striking “50” and inserting “33”; and

(II) in subclause (II), by striking “50” and inserting “67” and by striking “(B)(i)” and inserting “(B)(ii)”; and

(D) by striking subparagraph (D).

(4) DEFINITION.—Section 1834(a) (42 U.S.C. 1395m(a)) is amended by adding at the end the following new paragraph:

“(14) COVERED ITEM UPDATE.—In this subsection, the term ‘covered item update’ means, with respect to a year—

“(A) for 1991 and 1992, ¹³ reduction of 1 percentage point; and

“(B) for a subsequent year, the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year.”

¹³ So in original. Probably should be “a reduction”.

(5) CONFORMING AMENDMENT.—Section 1834(a)(12) (42 U.S.C. 1395m(a)(12)) is amended by striking “defined for purposes of paragraphs (8)(B) and (9)(B)”.

(c) TREATMENT OF “RENTAL CAP” ITEMS.—

(1) LIMITATION ON MONTHLY RECOGNIZED RENTAL AMOUNTS FOR MISCELLANEOUS ITEMS.—Section 1834(a)(7)(A)(i) (42 U.S.C. 1395m(a)(7)(A)(i)) is amended—

(A) by striking “for each such month” and inserting “for each of the first 3 months of such period”; and

(B) by striking the semicolon at the end and inserting the following: “, and for each of the remaining months of such period is 7.5 percent of such purchase price;”.

(2) OFFER OF OPTION TO PURCHASE FOR MISCELLANEOUS ITEMS; ESTABLISHMENT OF REASONABLE LIFETIME.—Section 1834(a)(7) of such Act (42 U.S.C. 1395m(a)(7)(A)) is amended—

(A) in subparagraph (A)(i), by striking “15 months” and inserting “15 months, or, in the case of an item for which a purchase agreement has been entered into under clause (iii), a period of continuous use of longer than 13 months”;

(B) in subparagraph (A)(ii)—

(i) by striking “(ii) during the succeeding 6-month period of medical need,” and inserting “(iv) in the case of an item for which a purchase agreement has not been entered into under clause (ii) or clause (iii), during the first 6-month period of medical need that follows the period of medical need during which payment is made under clause (i),”, and

(ii) by striking “and” at the end;

(C) in subparagraph (A)(iii)—

(i) by striking “(iii)” and inserting “(v) in the case of an item for which a purchase agreement has not been entered into under clause (ii) or clause (iii),”, and

(ii) by striking the period at the end and inserting “; and”;

(D) by inserting after clause (i) of subparagraph (A) the following new clauses:

“(ii) in the case of a power-driven wheelchair, at the time the supplier furnishes the item, the supplier shall offer the individual patient the option to purchase the item, and payment for such item shall be made on a lump-sum basis if the patient exercises such option;

“(iii) during the 10th continuous month during which payment is made for the rental of an item under clause (i), the supplier of such item shall offer the individual patient the option to enter into a purchase agreement under which, if the patient notifies the supplier not later than 1 month after the supplier makes such offer that the patient agrees to accept such offer and exercise such option—

“(I) the supplier shall transfer title to the item to the individual patient on the first day that begins after the 13th continuous month during which payment is made for the rental of the item under clause (i),

“(II) after the supplier transfers title to the item under subclause (I), maintenance and servicing

payments shall be made in accordance with clause (v);";

(E) by inserting after clause (v) of subparagraph (A) (as amended by subparagraph (C)) the following new clause:

"(vi) in the case of an item for which a purchase agreement has been entered into under clause (ii) or clause (iii), maintenance and servicing payments may be made (for parts and labor not covered by the supplier's or manufacturer's warranty, as determined by the Secretary to be appropriate for the particular type of durable medical equipment), and such payments shall be in an amount established by the Secretary on the basis of reasonable charges in the locality for maintenance and servicing."; and

(F) by adding at the end the following new subparagraph:
 "(C) REPLACEMENT OF ITEMS.—

"(i) ESTABLISHMENT OF REASONABLE USEFUL LIFETIME.—In accordance with clause (iii), the Secretary shall determine and establish a reasonable useful lifetime for items of durable medical equipment for which payment may be made under this paragraph or paragraph (3).

"(ii) PAYMENT FOR REPLACEMENT ITEMS.—If the reasonable lifetime of such an item, as so established, has been reached during a continuous period of medical need, or the carrier determines that the item is lost or irreparably damaged, the patient may elect to have payment for an item serving as a replacement for such item made—

"(I) on a monthly basis for the rental of the replacement item in accordance with subparagraph (A); or

"(II) in the case of an item for which a purchase agreement has been entered into under subparagraph (A)(ii) or (A)(iii), in a lump-sum amount for the purchase of the item.

"(iii) LENGTH OF REASONABLE USEFUL LIFETIME.—The reasonable useful lifetime of an item of durable medical equipment under this subparagraph shall be equal to 5 years, except that, if the Secretary determines that, on the basis of prior experience in making payments for such an item under this title, a reasonable useful lifetime of 5 years is not appropriate with respect to a particular item, the Secretary shall establish an alternative reasonable lifetime for such item."

(3) APPLICATION OF REASONABLE USEFUL LIFETIME FOR ITEMS REQUIRING FREQUENT AND SUBSTANTIAL SERVICING.—Section 1834(a)(3) (42 U.S.C. 1395m(a)(3)), as amended by subsection (b)(1), is further amended by adding at the end the following new subparagraph:

"(D) REPLACEMENT OF ITEMS.—If the reasonable useful lifetime of such an item, as established under paragraph (7)(C), has been reached during a continuous period of medical need, or the Secretary determines on the basis of investigation by the carrier that the item is lost or irreparably damaged, payment for an item serving as a replacement for such item shall be made on a monthly basis for the

rental of the replacement item in accordance with subparagraph (A).”.

(4) TREATMENT OF POWER-DRIVEN WHEELCHAIRS AS MISCELLANEOUS ITEMS OF DURABLE MEDICAL EQUIPMENT.—

(A) IN GENERAL.—Section 1834(a)(2)(A) (42 U.S.C. 1395m(a)(2)(A)) is amended—

- (i) in clause (i), by inserting “or” at the end;
- (ii) in clause (ii), by striking “or” at the end; and
- (iii) by striking clause (iii).

(B) CRITERIA FOR TREATMENT OF WHEELCHAIR AS CUSTOMIZED ITEM.—(i) Section 1834(a)(4) (42 U.S.C. 1395m(a)(4)) is amended by adding at the end the following: “In the case of a wheelchair furnished on or after January 1, 1992, the wheelchair shall be treated as a customized item for purposes of this paragraph if the wheelchair has been measured, fitted, or adapted in consideration of the patient’s body size, disability, period of need, or intended use, and has been assembled by a supplier or ordered from a manufacturer who makes available customized features, modifications, or components for wheelchairs that are intended for an individual patient’s use in accordance with instructions from the patient’s physician.”.

(ii) The amendment made by clause (i) shall apply to items furnished on or after January 1, 1992, unless the Secretary develops specific criteria before that date for the treatment of wheelchairs as customized items for purposes of section 1834(a)(4) of the Social Security Act (in which case the amendment made by such clause shall not become effective).

42 USC 1395m
note.

(d) FREEZE IN REASONABLE CHARGES FOR PARENTERAL AND ENTERAL NUTRIENTS, SUPPLIES, AND EQUIPMENT DURING 1991.—In determining the amount of payment under part B of title XVIII of the Social Security Act for enteral and parenteral nutrients, supplies, and equipment furnished during 1991, the charges determined to be reasonable with respect to such nutrients, supplies, and equipment may not exceed the charges determined to be reasonable with respect to such items for 1990.

42 USC 1395u
note.

(e) REQUIRING PRIOR APPROVAL FOR POTENTIALLY OVERUSED ITEMS.—Section 1834(a) (42 U.S.C. 1395m(a)), as amended by subsection (b), is amended by adding at the end the following new paragraph:

“(15) CARRIER DETERMINATIONS OF POTENTIALLY OVERUSED ITEMS IN ADVANCE.—

“(A) DEVELOPMENT OF LIST OF ITEMS BY SECRETARY.—The Secretary shall develop and periodically update a list of items for which payment may be made under this subsection that the Secretary determines, on the basis of prior payment experience, are frequently subject to unnecessary utilization, and shall include in such list seat-lift mechanisms, transcutaneous electrical nerve stimulators, and motorized scooters.

“(B) DETERMINATIONS OF COVERAGE IN ADVANCE.—A carrier shall determine in advance whether payment for an item included on the list developed by the Secretary under subparagraph (A) may not be made because of the application of section 1862(a)(1).”.

(f) PROHIBITION AGAINST DISTRIBUTION OF MEDICAL NECESSITY FORMS BY SUPPLIERS.—

(1) IN GENERAL.—Section 1834(a) (42 U.S.C. 1395m(a)), as amended by subsections (b) and (e), is further amended by adding at the end the following new paragraph:

“(16) PROHIBITION AGAINST DISTRIBUTION BY SUPPLIERS OF FORMS DOCUMENTING MEDICAL NECESSITY.—

“(A) IN GENERAL.—A supplier of a covered item under this subsection may not distribute to physicians or to individuals entitled to benefits under this part for commercial purposes any completed or partially completed forms or other documents required by the Secretary to be submitted to show that a covered item is reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

“(B) PENALTY.—Any supplier of a covered item who knowingly and willfully distributes a form or other document in violation of subparagraph (A) is subject to a civil money penalty in an amount not to exceed \$1,000 for each such form or document so distributed. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to civil money penalties under this subparagraph in the same manner as they apply to a penalty or proceeding under section 1128A(a).”.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to forms and documents distributed on or after January 1, 1991.

(g) RECERTIFICATION FOR CERTAIN PATIENTS RECEIVING HOME OXYGEN THERAPY SERVICES.—

(1) IN GENERAL.—Section 1834(a)(5) (42 U.S.C. 1395m(a)(5)) is amended—

(A) in subparagraph (A), by striking “(B) and (C)” and inserting “(B), (C), and (E)”;

(B) by adding at the end the following new subparagraph:

“(E) RECERTIFICATION FOR PATIENTS RECEIVING HOME OXYGEN THERAPY.—In the case of a patient receiving home oxygen therapy services who, at the time such services are initiated, has an initial arterial blood gas value at or above a partial pressure of 55 or an arterial oxygen saturation at or above 89 percent (or such other values, pressures, or criteria as the Secretary may specify) no payment may be made under this part for such services after the expiration of the 90-day period that begins on the date the patient first receives such services unless the patient’s attending physician certifies that, on the basis of a follow-up test of the patient’s arterial blood gas value or arterial oxygen saturation conducted during the final 30 days of such 90-day period, there is a medical need for the patient to continue to receive such services.”.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to patients who first receive home oxygen therapy services on or after January 1, 1991.

(h) TECHNICAL CORRECTIONS.—Effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1987, section 4062(e) of such Act is amended—

42 USC 1395m
note.

42 USC 1395m
note.

42 USC 1395f
note.

(1) by inserting “(other than oxygen and oxygen equipment)” after “covered items”, and

(2) by inserting before the period at the end the following: “and to oxygen and oxygen equipment furnished on or after June 1, 1989”.

(i) **EFFECTIVE DATE.**—Except as otherwise provided, the amendments made by this section shall apply to items furnished on or after January 1, 1991. 42 USC 1395m note.

SEC. 4153. PROVISIONS RELATING TO ORTHOTICS AND PROSTHETICS.

(a) **PAYMENTS FOR PROSTHETIC DEVICES AND ORTHOTICS AND PROSTHETICS.**—

(1) **MAINTAINING CURRENT PAYMENT METHODOLOGY.**—Section 1834 (42 U.S.C. 1395m) is amended by adding at the end the following new subsection:

“(h) **PAYMENT FOR PROSTHETIC DEVICES AND ORTHOTICS AND PROSTHETICS.**—

“(1) **GENERAL RULE FOR PAYMENT.**—

“(A) **IN GENERAL.**—Payment under this subsection for prosthetic devices and orthotics and prosthetics shall be made in a lump-sum amount for the purchase of the item in an amount equal to 80 percent of the payment basis described in subparagraph (B).

“(B) **PAYMENT BASIS.**—Except as provided in subparagraph (C), the payment basis described in this subparagraph is the lesser of—

“(i) the actual charge for the item; or

“(ii) the amount recognized under paragraph (2) as the purchase price for the item.

“(C) **EXCEPTION FOR CERTAIN PUBLIC HOME HEALTH AGENCIES.**—Subparagraph (B)(i) shall not apply to an item furnished by a public home health agency (or by another home health agency which demonstrates to the satisfaction of the Secretary that a significant portion of its patients are low income) free of charge or at nominal charges to the public.

“(D) **EXCLUSIVE PAYMENT RULE.**—This subsection shall constitute the exclusive provision of this title for payment for prosthetic devices, orthotics, and prosthetics under this part or under part A to a home health agency.

“(2) **PURCHASE PRICE RECOGNIZED.**—For purposes of paragraph (1), the amount that is recognized under this paragraph as the purchase price for prosthetic devices, orthotics, and prosthetics is the amount described in subparagraph (C) of this paragraph, determined as follows:

“(A) **COMPUTATION OF LOCAL PURCHASE PRICE.**—Each carrier under section 1842 shall compute a base local purchase price for the item as follows:

“(i) The carrier shall compute a base local purchase price for each item equal to the average reasonable charge in the locality for the purchase of the item for the 12-month period ending with June 1987.

“(ii) The carrier shall compute a local purchase price, with respect to the furnishing of each particular item—

“(I) in 1989 and 1990, equal to the base local purchase price computed under clause (i) increased by the percentage increase in the consumer price index for all urban consumers (United States city

average) for the 6-month period ending with December 1987, or

“(II) in 1991, 1992 or 1993, equal to the local purchase price computed under this clause for the previous year increased by the applicable percentage increase for the year.

“(B) COMPUTATION OF REGIONAL PURCHASE PRICE.—With respect to the furnishing of a particular item in each region (as defined by the Secretary), the Secretary shall compute a regional purchase price—

“(i) for 1992, equal to the average (weighted by relative volume of all claims among carriers) of the local purchase prices for the carriers in the region computed under subparagraph (A)(ii)(II) for the year, and

“(ii) for each subsequent year, equal to the regional purchase price computed under this subparagraph for the previous year increased by the applicable percentage increase for the year.

“(C) PURCHASE PRICE RECOGNIZED.—For purposes of paragraph (1) and subject to subparagraph (D), the amount that is recognized under this paragraph as the purchase price for each item furnished—

“(i) in 1989, 1990, or 1991, is 100 percent of the local purchase price computed under subparagraph (A)(ii);

“(ii) in 1992, is the sum of (I) 75 percent of the local purchase price computed under subparagraph (A)(ii)(II) for 1992, and (II) 25 percent of the regional purchase price computed under subparagraph (B) for 1992;

“(iii) in 1993, is the sum of (I) 50 percent of the local purchase price computed under subparagraph (A)(ii)(II) for 1993, and (II) 50 percent of the regional purchase price computed under subparagraph (B) for 1993; and

“(iv) in 1994 or a subsequent year, is the regional purchase price computed under subparagraph (B) for that year.

“(D) RANGE ON AMOUNT RECOGNIZED.—The amount that is recognized under subparagraph (C) as the purchase price for an item furnished—

“(i) in 1992, may not exceed 125 percent, and may not be lower than 85 percent, of the average of the purchase prices recognized under such subparagraph for all the carrier service areas in the United States in that year; and

“(ii) in a subsequent year, may not exceed 120 percent, and may not be lower than 90 percent, of the average of the purchase prices recognized under such subparagraph for all the carrier service areas in the United States in that year.

“(3) APPLICABILITY OF CERTAIN PROVISIONS RELATING TO DURABLE MEDICAL EQUIPMENT.—Paragraph (12) and subparagraphs (A) and (B) of paragraph (10) and paragraph (11) of subsection (a) shall apply to prosthetic devices, orthotics, and prosthetics in the same manner as such provisions apply to covered items under such subsection.

“(4) DEFINITIONS.—In this subsection—

“(A) the term ‘applicable percentage increase means—

“(i) for 1991, 0 percent, and

“(ii) for a subsequent year, the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year;

“(B) the term ‘prosthetic devices’ has the meaning given such term in section 1861(s)(8), except that such term does not include parenteral and enteral nutrition nutrients, supplies, and equipment; and

“(C) the term ‘orthotics and prosthetics’ has the meaning given such term in section 1861(s)(9), but does not include intraocular lenses or medical supplies (including catheters, catheter supplies, ostomy bags, and supplies related to ostomy care) furnished by a home health agency under section 1861(m)(5).”.

(2) CONFORMING AMENDMENTS.—(A) Section 1832(a)(2) (42 U.S.C. 1395k(a)(2)) is amended—

(i) in subparagraphs (A) and (B), by striking “subparagraph (G)” each place it appears and inserting “subparagraph (G) or subparagraph (I)”;

(ii) by striking “and” at the end of subparagraph (G);

(iii) by striking the period at the end of subparagraph (H) and inserting “; and”; and

(iv) by adding at the end the following new subparagraph:

“(I) prosthetic devices and orthotics and prosthetics (described in section 1834(h)(4)) furnished by a provider of services or by others under arrangements with them made by a provider of services.”.

(B) Section 1833(a)(1) (42 U.S.C. 1395l(a)(1)) is amended—

(i) by striking “, and (L)” and inserting “, (L)”;

(ii) by striking “subparagraph and (N)” and inserting the following: “subparagraph, (M) with respect to prosthetic devices and orthotics and prosthetics (as defined in section 1834(h)(4)), the amounts paid shall be the amounts described in section 1834(h)(1), and (N)”.

(C) Section 1833(a) (42 U.S.C. 1395l(a)) is amended—

(i) in paragraph (2), in the matter before subparagraph (A), by striking “and (H)” and inserting “(H), and (I)”;

(ii) by striking “and” at the end of paragraph (5);

(iii) by striking the period at the end of paragraph (6) and inserting “; and”; and

(iv) by adding at the end the following new paragraph:

“(7) in the case of prosthetic devices and orthotics and prosthetics (as described in section 1834(h)(4)), the amounts described in section 1834(h).”.

(D) Section 1834(a) (42 U.S.C. 1395m(a)), is amended—

(i) in the heading, by striking “, PROSTHETIC DEVICES, ORTHOTICS, AND PROSTHETICS”;

(ii) in paragraph (2)(A), by striking “(13)(A)” and inserting “(13)”;

(iii) in paragraph (13), by striking “means—” and all that follows and inserting the following: “means durable medical equipment (as defined in section 1861(n)), including such equipment described in section 1861(m)(5)).”.

(3) EFFECTIVE DATE.—The amendments made by paragraphs (1) and (2) shall apply to items furnished on or after January 1, 1991. 42 USC 1395k note.

(b) PROVISIONS RELATING TO EYEGLASSES.—

42 USC 1395u
note.

(1) **PROHIBITION ON REGULATIONS.**—(A) Notwithstanding any other provision of law (except as provided in subparagraph (B)) the Secretary of Health and Human Services (referred to in this subsection as the “Secretary”) may not issue any regulation that changes the coverage of conventional eyewear furnished to individuals (enrolled under part B of title XVIII of the Social Security Act) following cataract surgery with insertion of an intraocular lens.

(B) Paragraph (1) shall not apply to any regulation issued for the sole purpose of implementing the amendments made by paragraph (2).

(2) **CLARIFYING COVERAGE OF POST-CATARACT EYEGLASSES.**—(A) Section 1861(s)(8) (42 U.S.C. 1395x(s)(8)) is amended by inserting after “such devices” the following “, and including one pair of conventional eyeglasses or contact lenses furnished subsequent to each cataract surgery with insertion of an intraocular lens”.

(B) Section 1862(a)(7) (42 U.S.C. 1395y(a)(7)) is amended by inserting after “eyeglasses” the first place it appears the following: “(other than eyewear described in section 1861(s)(8))”.

(C) The amendments made by subparagraphs (A) and (B) shall apply to items furnished on or after January 1, 1991.

(c) **GAO STUDY OF MEDICARE PAYMENTS FOR PROSTHETIC DEVICES, ORTHOTICS, AND PROSTHETICS.**—

(1) **STUDY.**—The Comptroller General shall conduct a study of the feasibility and desirability of establishing a separate fee schedule for use in determining the amount of payments for covered items under section 1834(a) of the Social Security Act with respect to suppliers of prosthetic devices, orthotics, and prosthetics who provide professional services that would take into account the costs to such providers of providing such services.

(2) **REPORT.**—Not later than 1 year after the date of the enactment of this Act, the Comptroller General shall submit a report on the study conducted under subparagraph (A) to the Committees on Energy and Commerce and Ways and Means of the House of Representatives and the Committee on Finance of the Senate, and shall include in such report any recommendations regarding payments for prosthetic devices, orthotics, and prosthetics under the medicare program that the Comptroller General considers appropriate.

(d) **CLARIFICATION OF COVERAGE OF OSTOMY SUPPLIES.**—

(1) **IN GENERAL.**—Section 1866(a)(1)(P) (42 U.S.C. 1395cc(a)(1)(P)) is amended by striking “ostomy supplies” and inserting “catheters, catheter supplies, ostomy bags, and supplies related to ostomy care”.

(2) **EFFECTIVE DATE.**—The amendment made by paragraph (1) shall take effect as if included in the enactment of the Omnibus Budget Reconciliation¹⁴ Act of 1989.

SEC. 4154. CLINICAL DIAGNOSTIC LABORATORY TESTS.

(a) **LIMIT ON ANNUAL FEE SCHEDULE INCREASES.**—Section 1833(h)(2)(A)(ii) (42 U.S.C. 1395l(h)(2)(A)(ii)) is amended—

(1) by striking “any other provision of this subsection” and inserting “clause (i)”;

(2) by striking “and” at the end of subclause (I);

(3) by striking the period at the end of subclause (II) and inserting “, and”; and

¹⁴ So in original. Probably should be “Reconciliation”.

42 USC 1395x
note.

42 USC 1395m
note.

42 USC 1395cc
note.

(4) by adding at the end the following new subclause:

“(III) the annual adjustment in the fee schedules determined under clause (i) for each of the years 1991, 1992, and 1993 shall be 2 percent.”.

(b) REDUCTION IN NATIONAL CAP ON FEE SCHEDULES.—

(1) **IN GENERAL.**—Section 1833(h)(4)(B) (42 U.S.C. 1395l(h)(4)(B)) is amended—

(A) in clause (ii), by striking “and” at the end;

(B) in clause (iii)—

(i) by inserting “and before January 1, 1991,” after “1989,” and

(ii) by striking the period at the end and inserting “, and”; and

(C) by adding at the end the following new clause:

“(iv) after December 31, 1990, is equal to 88 percent of the median of all the fee schedules established for that test for that laboratory setting under paragraph (1).”.

(2) **EFFECTIVE DATE.**—The amendments made by paragraph (1) shall apply to tests furnished on or after January 1, 1991. 42 USC 1395l note.

(c) CLARIFICATION OF MANDATORY ASSIGNMENT FOR CLINICAL DIAGNOSTIC LABORATORY TESTS PERFORMED BY PHYSICIANS.—

(1) **IN GENERAL.**—(A) Section 1833(h)(5)(C) of such Act (42 U.S.C. 1395l(h)(5)(C)) is amended by striking “test performed by a laboratory other than a rural health clinic” and inserting “test, including a test performed in a physician’s office but excluding a test performed by a rural health clinic”.

(B) Section 1833(h)(5)(D) of such Act (42 U.S.C. 1395l(i)(5)(D)) is amended by striking “test performed by a laboratory, other than a rural health clinic” and inserting “test, including a test performed in a physician’s office but excluding a test performed by a rural health clinic,”.

(2) **EFFECTIVE DATE.**—The amendment made by paragraph (1)(A) shall take effect as if included in the enactment of the Consolidated Omnibus Budget Reconciliation Act of 1985, and the amendment made by paragraph (1)(B) shall take effect as if included in the enactment of the Omnibus Budget Reconciliation Act of 1987. 42 USC 1395l note.

(d) AGREEMENTS WITH STATES TO DETERMINE COMPLIANCE OF CLINICAL LABORATORIES WITH PROGRAM REQUIREMENTS.—

(1) **IN GENERAL.**—Section 1864(a) (42 U.S.C. 1395aa(a)) is amended in the first sentence by striking “1861(s),” and inserting “1861(s) or (in the case of a laboratory that does not participate or seek to participate in the medicare program) the requirements of section 353 of the Public Health Service Act,”.

(2) **EFFECTIVE DATE.**—The amendment made by paragraph (1) shall take effect as if included in the enactment of the Clinical Laboratory Improvement Amendments of 1988. 42 USC 1395aa note.

(e) TECHNICAL CORRECTIONS.—

(1) Section 1833(h)(5)(A)(ii) of such Act (42 U.S.C. 1395l(h)(5)(A)(ii)) is amended—

(A) in subclause (II), by striking “a wholly-owned subsidiary of” and inserting “wholly owned by”;

(B) in subclause (III), by striking “laboratory” and inserting “laboratory (but not including a laboratory described in subclause (II)),”; and

(C) in subclause (III), by striking “submits bills or requests for payment in any year” and inserting “receives

requests for testing during the year in which the test is performed”.

42 USC 1395w-2.

(2) The heading of section 1846 of such Act is amended by striking “OF” and inserting “OR SUPPLIERS OF”.

42 USC 1395l
note.

(3) Effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1986, section 9339(b) of the Omnibus Budget Reconciliation Act of 1986 is amended by striking paragraph (3).

42 USC 1395l
note.

(4) Section 6111(b)(2) of the Omnibus Budget Reconciliation Act of 1989 is amended by striking “January 1, 1990” and inserting “May 1, 1990”

42 USC 1395l
note.

(5) The amendments made by paragraphs (1)(A)¹⁵ (1)(B), (2), and (4) shall take effect as if included in the enactment of the Omnibus Budget Reconciliation Act of 1989, and the amendment made by paragraph (1)(C) shall take effect January 1, 1991.

SEC. 4155. COVERAGE OF NURSE PRACTITIONERS IN RURAL AREAS.

(a) **IN GENERAL.**—Section 1861(s)(2)(K) (42 U.S.C. 1395x(s)(2)(K)) is amended—

- (1) in clause (ii), by striking “and” at the end;
- (2) by redesignating clause (iii) as clause (iv); and
- (3) by inserting after clause (ii) the following new clause:
“(iii) services which would be physicians’ services if furnished by a physician (as defined in subsection (r)(1)) and which are performed by a nurse practitioner or clinical nurse specialist (as defined in subsection (aa)(3)) working in collaboration (as defined in subsection (aa)(4)) with a physician (as defined in subsection (r)(1)) in a rural area (as defined in section 1886(d)(2)(D)) which the nurse practitioner or clinical nurse specialist is authorized to perform by the State in which the services are performed, and such services and supplies furnished as an incident to such services as would be covered under subparagraph (A) if furnished as an incident to a physician’s professional service, and”.

(b) **PAYMENT.**—

(1) **DIRECT PAYMENT.**—Section 1832(a)(2)(B) (42 U.S.C. 1395k(a)(2)(B)) is amended—

- (A) in clause (ii), by striking “and” at the end;
- (B) in clause (iii), by striking the semicolon and inserting a comma; and
- (C) by adding at the end the following new clause:
“(iv) services of a nurse practitioner or clinical nurse specialist provided in a rural area (as defined in section 1886(d)(2)(D)); and”.

(2) **AMOUNT.**—Section 1833(a)(1) (42 U.S.C. 1395l(a)(1)) as amended by section 4153(a)(2)(B), is amended—

- (A) by striking “and” at the end of subparagraph (K); and
- (B) by inserting after subparagraph (L) the following new subparagraph: “(M) with respect to services described in section 1861(s)(2)(K)(iii) (relating to nurse practitioner or clinical nurse specialist services provided in a rural area), the amounts paid shall be 80 percent of the lesser of the actual charge or the prevailing charge that would be recognized (or, for services furnished on or after January 1, 1992, the fee schedule amount provided under section 1848) if the

¹⁵ So in original. Probably should be “(1)(A).”

services had been performed by a physician (subject to the limitation described in subsection (r)(2))”.

(3) CAP ON PREVAILING CHARGE; BILLING ONLY ON ASSIGNMENT-RELATED BASIS.—Section 1833 (42 U.S.C. 1395l) is amended by adding at the end the following new subsection:

“(r)(1) With respect to services described in section 1861(s)(2)(K)(iii) (relating to nurse practitioner or clinical nurse specialist services provided in a rural area), payment may be made on the basis of a claim or request for payment presented by the nurse practitioner or clinical nurse specialist furnishing such services, or by a hospital, rural primary care hospital, skilled nursing facility or nursing facility (as defined in section 1919(a)), physician, group practice, ambulatory surgical center, with which the nurse practitioner or clinical nurse specialist has an employment or contractual relationship that provides for payment to be made under this part for such services to such hospital, physician, group practice, ambulatory surgical center.

“(2)(A) For purposes of subsection (a)(1)(M), the prevailing charge for services described in section 1861(s)(2)(K)(iii) may not exceed the applicable percentage (as defined in subparagraph (B)) of the prevailing charge (or, for services furnished on or after January 1, 1992, the fee schedule amount provided under section 1848) determined for such services performed by physicians who are not specialists.

“(B) In subparagraph (A), the term ‘applicable percentage’ means—

“(i) 75 percent in the case of services performed in a hospital, and

“(ii) 85 percent in the case of other services.

“(3)(A) Payment under this part for services described in section 1861(s)(2)(K)(iii) may be made only on an assignment-related basis, and any such assignment agreed to by a nurse practitioner or clinical nurse specialist shall be binding upon any other person presenting a claim or request for payment for such services.

“(B) Except for deductible and coinsurance amounts applicable under this section, any person who knowingly and willfully presents, or causes to be presented, to an individual enrolled under this part a bill or request for payment for services described in section 1861(s)(2)(K)(iii) in violation of subparagraph (A) is subject to a civil money penalty of not to exceed \$2,000 for each such bill or request. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

“(4) No hospital or rural primary care hospital that presents a claim or request for payment under this part for services described in section 1861(s)(2)(K)(iii) may treat any uncollected coinsurance amount imposed under this part with respect to such services as a bad debt of such hospital for purposes of this title.”.

(c) CONFORMING AMENDMENT.—Section 1842(b) (42 U.S.C. 1395u(b)) is amended by striking “section 1861(s)(2)(K)” each place it appears in paragraphs (6) and (12) and inserting “clauses (i), (ii), or (iv) of section 1861(s)(2)(K)”.

(d) DEFINITION.—Section 1861(aa)(3) (42 U.S.C. 1395x(aa)(3)) is amended by striking “The term” and all that follows through “who performs” and inserting the following: “The term ‘physician assistant’, the term ‘nurse practitioner’, and the term ‘clinical nurse

42 USC 1395k
note.

specialist' mean, for purposes of this Act, a physician assistant, nurse practitioner, or clinical nurse specialist who performs".

(e) **EFFECTIVE DATE.**—The amendments made by this section shall apply to services furnished on or after January 1, 1991.

SEC. 4156. COVERAGE OF INJECTABLE DRUGS FOR TREATMENT OF OSTEOPOROSIS.

(a) **IN GENERAL.**—Section 1861 (42 U.S.C. 1395x) is amended—
(1) in subsection (s)(2)—

(A) by striking "and" at the end of subparagraph (M),

(B) by inserting "and" at the end of subparagraph (N),

and

(C) by inserting after subparagraph (N) the following new subparagraph:

"(O) a covered osteoporosis drug and its administration (as defined in subsection (jj)) furnished on or after January 1, 1991, and on or before December 31, 1995; and"; and

(2) by inserting after subsection (ii) the following new subsection:

"Covered Osteoporosis Drug

"(jj) The term 'covered osteoporosis drug' means an injectable drug approved for the treatment of a bone fracture related to post-menopausal osteoporosis provided to an individual if, in accordance with regulations promulgated by the Secretary—

"(1) the individual's attending physician certifies that the patient is unable to learn the skills needed to self-administer such drug or is otherwise physically or mentally incapable of self-administering such drug; and

"(2) the individual is confined to the individual's home (except when receiving items and services referred to in subsection (m)(7))."

42 USC 1395x
note.

(b) **STUDY OF EFFECTS OF COVERAGE.**—

(1) **IN GENERAL.**—The Secretary of Health and Human Services shall conduct a study analyzing the effects of coverage of osteoporosis drugs under part B of title XVIII of the Social Security Act (as amended by subsection (a)) on the health of individuals enrolled under such part and the utilization of inpatient hospital and extended care services by such individuals.

(2) **REPORT.**—By not later than October 1, 1994, the Secretary shall submit a report to Congress on the study conducted under paragraph (1), and shall include in such report such recommendations regarding expansion of coverage under the medicare program of items and services for individuals with post-menopausal osteoporosis as the Secretary considers appropriate.

SEC. 4157. SEPARATE PAYMENT UNDER PART B FOR SERVICES OF CERTAIN HEALTH PRACTITIONERS.

(a) **SERVICES OF CERTAIN HEALTH PRACTITIONERS NOT TO BE INCLUDED IN INPATIENT HOSPITAL SERVICES.**—Section 1861(b) (42 U.S.C. 1395x(b)) is amended—

(1) in paragraph (3), by striking "(including clinical psychologist (as defined by the Secretary))", and

(2) in paragraph (4), by striking everything after “intern” and inserting “, services described by subsection (s)(2)(K)(i), certified nurse-midwife services, qualified psychologist services, and services of a certified registered nurse anesthetist; and”.

(b) **TREATMENT OF SERVICES FURNISHED IN INPATIENT SETTING.**—Section 1832(a)(2)(B)(iii) (42 U.S.C. 1395k(a)(2)(B)(iii)) is amended to read as follows:

“(iii) services described by section 1861(s)(2)(K)(i), certified nurse-midwife services, qualified psychologist services, and services of a certified registered nurse anesthetist;”

(c) **CONFORMING AMENDMENTS.**—

(1) Section 1862(a)(14) (42 U.S.C. 1395y) is amended—

(A) by striking “or are services of a certified registered nurse anesthetist”, and

(B) by inserting after “this paragraph)” a comma and the following: “services described by section 1861(s)(2)(K)(i), certified nurse-midwife services, qualified psychologist services, and services of a certified registered nurse anesthetist,”.

(2) The matter in section 1866(a)(1)(H) (42 U.S.C. 1395x(a)(1)(H)) preceding clause (i) is amended by inserting after “and other than” the following: “services described by section 1861(s)(2)(K)(i), certified nurse-midwife services, qualified psychologist services, and”.

(d) **EFFECTIVE DATE.**—The amendments made by the preceding subsections apply to services furnished on or after January 1, 1991.

SEC. 4158. REDUCTION IN PAYMENTS UNDER PART B DURING FINAL 2 MONTHS OF 1990.

(a) **IN GENERAL.**—Notwithstanding any other provision of law (including any other provision of this Act, other than subsection (b)(4)), payments under part B of title XVIII of the Social Security Act for items and services furnished during the period beginning on November 1, 1990, and ending on December 31, 1990, shall be reduced by 2 percent, in accordance with subsection (b).

(b) **SPECIAL RULES FOR APPLICATION OF REDUCTION.**—

(1) **PAYMENT ON THE BASIS OF COST REPORTING PERIODS.**—In the case in which payment for services of a provider of services is made under part B of such title on a basis relating to the reasonable cost incurred for the services during a cost reporting period of the provider, the reduction made under subsection (a) shall be applied to payment for costs for such services incurred at any time during each cost reporting period of the provider any part of which occurs during the period described in such subsection, but only in the same proportion as the fraction of the cost reporting period that occurs during such period.

(2) **NO INCREASE IN BENEFICIARY CHARGES IN ASSIGNMENT-RELATED CASES.**—If a reduction in payment amounts is made under subsection (a) for items or services for which payment under part B of such title is made on an assignment-related basis (as defined in section 1842(i)(1) of the Social Security Act), the person furnishing the items or services shall be considered to have accepted payment of the reasonable charge for the items or services, less any reduction in payment amount made under subsection (a), as payment in full.

(3) TREATMENT OF PAYMENTS TO HEALTH MAINTENANCE ORGANIZATIONS.—Subsection (a) shall not apply to payments under risk-sharing contracts under section 1876 of the Social Security Act or under similar contracts under section 402 of the Social Security Amendments of 1967 or section 222 of the Social Security Amendments of 1972.

42 USC 1395ww
note.

SEC. 4159. PAYMENTS FOR MEDICAL EDUCATION COSTS.

(a) HOSPITAL GRADUATE MEDICAL EDUCATION RECOUPMENT.—

(1) IN GENERAL.—The Secretary of Health and Human Services may not, before October 1, 1991, recoup payments from a hospital because of alleged overpayments to such hospital under part B of title XVIII of the Social Security Act due to a determination that the amount of payments made for graduate medical education programs exceeds the amount allowable under section 1886(h).

(2) CAP ON ANNUAL AMOUNT OF RECOUPMENT.—With respect to overpayments to a hospital described in paragraph (1), the Secretary may not recoup more than 25 percent of the amount of such overpayments from the hospital during a fiscal year.

(3) EFFECTIVE DATE.—Paragraphs (1) and (2) shall take effect October 1, 1990.

(b) UNIVERSITY HOSPITAL NURSING EDUCATION.—

(1) IN GENERAL.—The reasonable costs incurred by a hospital (or by an educational institution related to the hospital by common ownership or control) during a cost reporting period for clinical training (as defined by the Secretary) conducted on the premises of the hospital under approved nursing and allied health education programs that are not operated by the hospital shall be allowable as reasonable costs under part B of title XVIII of the Social Security Act and reimbursed under such part on a pass-through basis.

(2) CONDITIONS FOR REIMBURSEMENT.—The reasonable costs incurred by a hospital during a cost reporting period shall be reimbursable pursuant to paragraph (1) only if—

(A) the hospital claimed and was reimbursed for such costs during the most recent cost reporting period that ended on or before October 1, 1989;

(B) the proportion of the hospital's total allowable costs that is attributable to the clinical training costs of the approved program, and allowable under (b)(1) during the cost reporting period does not exceed the proportion of total allowable costs that were attributable to clinical training costs during the cost reporting period described in subparagraph (A);

(C) the hospital receives a benefit for the support it furnishes to such program through the provision of clinical services by nursing or allied health students participating in such program; and

(D) the costs incurred by the hospital for such program do not exceed the costs that would be incurred by the hospital if it operated the program itself.

(3) PROHIBITION AGAINST RECOUPMENT OF COSTS BY SECRETARY.—

(A) IN GENERAL.—The Secretary of Health and Human Services may not recoup payments from (or otherwise reduce or adjust payments under part B of title XVIII of the

Social Security Act to) a hospital because of alleged overpayments to such hospital under such title due to a determination that costs which were reported by the hospital on its medicare cost reports for cost reporting periods beginning on or after October 1, 1983, and before October 1, 1990, relating to approved nursing and allied health education programs did not meet the requirements for allowable nursing and allied health education costs (as developed by the Secretary pursuant to section 1861(v) of such Act).

(B) REFUND OF AMOUNTS RECOUPED.—If, prior to the date of the enactment of this Act, the Secretary has recouped payments from (or otherwise reduced or adjusted payments under part B of title XVIII of the Social Security Act to) a hospital because of overpayments described in subparagraph (A), the Secretary shall refund the amount recouped, reduced, or adjusted from the hospital.

(4) SPECIAL AUDIT TO DETERMINE COSTS.—In determining the amount of costs incurred by, claimed by, and reimbursed to, a hospital for purposes of this subsection, the Secretary shall conduct a special audit (or use such other appropriate mechanism) to ensure the accuracy of such past claims and payments.

(5) EFFECTIVE DATE.—Except as provided in paragraph (3), the provisions of this subsection shall apply to cost reporting periods beginning on or after October 1, 1990.

SEC. 4160. CERTIFIED REGISTERED NURSE ANESTHETISTS.

Section 1833(l) (42 U.S.C. 1395l) is amended—

(1) in paragraph (1)—

(A) by inserting “(A)” after “(1)”; and

(B) by adding at the end the following:

“(B) In establishing the fee schedule under this paragraph the Secretary may utilize a system of time units, a system of base and time units, or any appropriate methodology.

“(C) The provisions of this subsection shall not apply to certain services furnished in certain hospitals in rural areas under the provisions of section 9320(k) of the Omnibus Budget Reconciliation Act of 1986, as amended by section 6132 of the Omnibus Budget Reconciliation Act of 1989.”;

(2) by striking the second sentence of paragraph (2); and

(3) by striking paragraph (4) and inserting the following:

“(4)(A) Except as provided in subparagraphs (C) and (D), in determining the amount paid under the fee schedule under this subsection for services furnished on or after January 1, 1991, by a certified registered nurse anesthetist who is not medically directed—

“(i) the conversion factor shall be—

“(I) for services furnished in 1991, \$15.50,

“(II) for services furnished in 1992, \$15.75,

“(III) for services furnished in 1993, \$16.00,

“(IV) for services furnished in 1994, \$16.25,

“(V) for services furnished in 1995, \$16.50,

“(VI) for services furnished in 1996, \$16.75, and

“(VII) for services furnished in calendar years after 1996, the previous year’s conversion factor increased by the update determined under section 1848(d)(3) for physician anesthesia services for that year;

“(ii) the payment areas to be used shall be the fee schedule areas used under section 1848 (or, in the case of services fur-

nished during 1991, the localities used under section 1842(b)) for purposes of computing payments for physicians' services that are anesthesia services;

“(iii) the geographic adjustment factors to be applied to the conversion factor under clause (i) for services in a fee schedule area or locality is—

“(I) in the case of services furnished in 1991, the geographic work index value and the geographic practice cost index value specified in section 1842(q)(1)(B) for physicians' services that are anesthesia services furnished in the area or locality, and

“(II) in the case of services furnished after 1991, the geographic work index value, the geographic practice cost index value, and the geographic malpractice index value used for determining payments for physicians' services that are anesthesia services under section 1848,

with 70 percent of the conversion factor treated as attributable to work and 30 percent as attributable to overhead for services furnished in 1991 (and the portions attributable to work, practice expenses, and malpractice expenses in 1992 and thereafter being the same as is applied under section 1848).

“(B)(i) Except as provided in clause (ii) and subparagraph (D), in determining the amount paid under the fee schedule under this subsection for services furnished on or after January 1, 1991, by a certified registered nurse anesthetist who is medically directed, the Secretary shall apply the same methodology specified in subparagraph (A).

“(ii) The conversion factor used under clause (i) shall be—

“(I) for services furnished in 1991, \$10.50,

“(II) for services furnished in 1992, \$10.75,

“(III) for services furnished in 1993, \$11.00,

“(IV) for services furnished in 1994, \$11.25,

“(V) for services furnished in 1995, \$11.50,

“(VI) for services furnished in 1996, \$11.70, and

“(VII) for services furnished in calendar years after 1997, the previous year's conversion factor increased by the update determined under section 1848(d)(3) for physician anesthesia services for that year.

“(C) Notwithstanding subclauses (I) through (V) of subparagraph (A)(i)—

“(i) in the case of a 1990 conversion factor that is greater than \$16.50, the conversion factor for a calendar year after 1990 and before 1996 shall be the 1990 conversion factor reduced by the product of the last digit of the calendar year and one-fifth of the amount by which the 1990 conversion factor exceeds \$16.50; and

“(ii) in the case of a 1990 conversion factor that is greater than \$15.49 but less than \$16.51, the conversion factor for a calendar year after 1990 and before 1996 shall be the greater of—

“(I) the 1990 conversion factor, or

“(II) the conversion factor specified in subparagraph (A)(i) for the year involved.

“(D) Notwithstanding subparagraph (C), in no case may the conversion factor used to determine payment for services in a fee schedule area or locality under this subsection, as adjusted by the adjustment factors specified in subparagraphs (A)(iii), exceed the

conversion factor used to determine the amount paid for physicians' services that are anesthesia services in the area or locality."

SEC. 4161. COMMUNITY HEALTH CENTERS AND RURAL HEALTH CLINICS.

(a) COMMUNITY HEALTH CENTERS.—

(1) **COVERAGE.**—Section 1861(s)(2)(E) of the Social Security Act (42 U.S.C. 1395x(s)(2)(E)) is amended by inserting "and Federally qualified health center services" after "rural health clinic services".

(2) **SERVICES DEFINED.**—Section 1861(aa) of such Act is amended—

(A) in the heading, by adding at the end the following:
"and Federally Qualified Health Center Services",

(B) in paragraph (3), by striking "paragraphs (1) and (2)" and inserting "the previous provisions of this subsection" and by redesignating such paragraph and paragraph (4) as paragraph (5) and (6), respectively, and

(C) by inserting after paragraph (2) the following new paragraphs:

"(3) The term 'Federally qualified health center services' means—

"(A) services of the type described in subparagraphs (A) through (C) of paragraph (1), and

"(B) preventive primary health services that a center is required to provide under sections 329, 330, and 340 of the Public Health Service Act,

when furnished to an individual as an outpatient of a Federally qualified health center and, for this purpose, any reference to a rural health clinic or a physician described in paragraph (2)(B) is deemed a reference to a Federally qualified health center or a physician at the center, respectively.

"(4) The term 'Federally qualified health center' means an entity which—

"(A)(i) is receiving a grant under section 329, 330, or 340 of the Public Health Service Act, or

"(ii)(I) is receiving funding from such a grant under a contract with the recipient of such a grant, and (II) meets the requirements to receive a grant under section 329, 330, or 340 of such Act;

"(B) based on the recommendation of the Health Resources and Services Administration within the Public Health Service, is determined by the Secretary to meet the requirements for receiving such a grant; or

"(C) was treated by the Secretary, for purposes of part B, as a comprehensive Federally funded health center as of January 1, 1990."

(3) PAYMENTS.—

(A) **IN GENERAL.**—Section 1832(a)(2)(D) of such Act (42 U.S.C. 1395k(a)(2)(D)) is amended by inserting "(i)" after "(D)" and by inserting "and (ii) Federally qualified health center services" after "rural health clinic services".

(B) **DEDUCTIBLE DOES NOT APPLY.**—The first sentence of section 1833(b) of such Act (42 U.S.C. 1395l(b)) is amended—

(i) by striking "and" before "(4)",

(ii) by inserting before the period at the end the following: ", and (5) such deductible shall not apply to Federally qualified health center services".

(C) **EXCLUSION FROM PAYMENT REMOVED.**—Section 1862(a) of such Act (42 U.S.C. 1395y(a)) is amended—

(i) in paragraph (2), by inserting “, except in the case of Federally qualified health center services” before the semicolon at the end, and

(ii) in paragraph (3), by inserting “, in the case of Federally qualified health center services, as defined in section 1861(aa)(3),” after “1861(aa)(1),” and

(iii) by adding at the end the following new sentence: “Paragraph (7) shall not apply to Federally qualified health center services described in section 1861(aa)(3)(B).”

(4) **WAIVER OF ANTI-KICKBACK REQUIREMENT.**—Section 1128B(b)(3) of such Act (42 U.S.C. 1320a-7b(b)(3)) is amended—

(A) by striking “and” at the end of subparagraph (C),

(B) by redesignating subparagraph (D) as subparagraph (E), and

(C) by inserting after subparagraph (C) the following new subparagraph:

“(D) a waiver of any coinsurance under part B of title XVIII by a Federally qualified health care center with respect to an individual who qualifies for subsidized services under a provision of the Public Health Service Act; and”.

(5) **CONFORMING AMENDMENTS.**—Section 1861 of such Act (42 U.S.C. 1395x) is further amended—

(A) in subsections (s)(2)(H)(i) and (s)(2)(K), by striking “subsection (aa)(3)” and “subsection (aa)(4)” each place either appears inserting “subsection (aa)(5)” and “subsection (aa)(6)”, respectively, and

(B) in subsection (aa)(1)(B), by striking “paragraph (3)” and inserting “paragraph (5)”.

(6) **PRRB REVIEW OF COST REPORTS FOR FEDERALLY QUALIFIED HEALTH CENTERS.**—Section 1878 of the Social Security Act (42 U.S.C. 1395oo) is amended by adding at the end the following new subsection:

“(j) In this section, the term ‘provider of services’ includes a Federally qualified health center.”.

(7) **GAO STUDY OF HOSPITAL STAFF PRIVILEGES FOR PHYSICIANS PRACTICING IN COMMUNITY HEALTH CENTERS.**—

(A) **STUDY.**—The Comptroller General shall conduct a study of whether physicians practicing in community and migrant health centers are able to obtain admitting privileges at local hospitals. The study shall review—

(i) how many physicians practicing in such centers are without hospital admitting privileges or have been denied admitting privileges at a local hospital, and

(ii) the criteria hospitals use in deciding whether to grant admitting privileges and (II) whether such criteria act as significant barriers to health center physicians obtaining hospital privileges.

(B) **REPORT.**—By not later than 18 months after the date of the enactment of this Act, the Comptroller General shall submit a report on the study under subparagraph (A) to the Committees on Ways and Means and Energy and Commerce of the House of Representatives and shall include in such report such recommendations as the Comptroller General deems appropriate.

(8) **EFFECTIVE DATE.**—(A) Subject to subparagraphs (B) and (C), the amendments made by this section shall apply to services furnished on or after October 1, 1991. 42 USC 1395k note.

(B) In the case of a Federally qualified health care center that has elected, as of January 1, 1990, under part B of title XVIII of the Social Security Act, to have the amount of payments for services under such part determined on a reasonable-charge basis, the amendment made by paragraph (3)(A) shall only apply on and after such date (not earlier than October 1, 1991) as the center may elect.

(C) The amendment made by paragraph (6) shall apply to cost reports for periods beginning on or after October 1, 1991.

(b) RURAL HEALTH CLINIC SERVICES.—

(1) **EXPEDITED CERTIFICATION.**—Section 1861(aa)(2) of the Social Security Act (42 U.S.C. 1395x(aa)(2)) is amended by adding at the end the following: “If a State agency has determined under section 1864(a) that a facility is a rural health clinic and the facility has applied to the Secretary for certification as such a clinic, the Secretary shall notify the facility of the the Secretary’s approval or disapproval of the certification not later than 60 days after the date of the State agency determination or the application (whichever is later).”.

(2) **TEMPORARY WAIVER OF STAFFING REQUIREMENTS.**—Section 1861(aa) of such Act, as amended by subsection (a), is further amended by adding at the end the following new paragraph: “(7)(A) The Secretary shall waive for a 1-year period the requirements of paragraph (2) that a rural health clinic employ a physician assistant, nurse practitioner or certified nurse midwife or that such clinic require such providers to furnish services at least 50 percent of the time that the clinic operates for any facility that requests such waiver if the facility demonstrates that the facility has been unable, despite reasonable efforts, to hire a physician assistant, nurse practitioner, or certified nurse-midwife in the previous 90-day period.

“(B) The Secretary may not grant such a waiver under subparagraph (A) to a facility if the request for the waiver is made less than 6 months after the date of the expiration of any previous such waiver for the facility.

“(C) A waiver which is requested under this paragraph shall be deemed granted unless such request is denied by the Secretary within 60 days after the date such request is received.”.

(3) **PRODUCTIVITY SCREENS.**—In employing any screening guideline in determining the productivity of physicians, physician assistants, nurse practitioners, and certified nurse-midwives in a rural health clinic, the Secretary of Health and Human Services shall provide that the guideline shall take into account the combined services of such staff (and not merely the service within each class of practitioner). 42 USC 1395x note.

(4) **PRRB REVIEW OF COST REPORTS FOR RURAL HEALTH CENTERS.**—Section 1878(j) of the Social Security Act (42 U.S.C. 1395o(j)), as added by subsection (a)(6), is amended by inserting “a rural health clinic and” after “includes”.

(5) **EFFECTIVE DATE.**—This subsection shall take effect on October 1, 1991, except that the amendment made by paragraph (4) shall apply to cost reports for periods beginning on or after October 1, 1991. 42 USC 1395x note.

SEC. 4162. PARTIAL HOSPITALIZATION IN COMMUNITY MENTAL HEALTH CENTERS.

(a) **IN GENERAL.**—Section 1861(ff)(3) of the Social Security Act (42 U.S.C. 1395x(ff)(3)) is amended—

(1) by striking “(3)” and inserting “(3)(A)”;

(2) by striking “outpatients” and inserting “outpatients or by a community mental health center (as defined in subparagraph (B)),”; and

(3) by adding at the end the following new subparagraph:
“(B) For purposes of subparagraph (A), the term ‘community mental health center’ means an entity—

“(i) providing the services described in section 1916(c)(4) of the Public Health Service Act; and

“(ii) meeting applicable licensing or certification requirements for community mental health centers in the State in which it is located.”.

(b) **CONFORMING AMENDMENTS.**—(1) Section 1832(a)(2) of such Act (42 U.S.C. 1395k(a)(2)) as amended by section 4153(a)(2)(A), is amended—

(A) by striking “and” at the end of subparagraph (H);

(B) by striking the period at the end of subparagraph (I) and inserting “; and”; and

(C) by adding at the end the following new subparagraph:

“(J) partial hospitalization services provided by a community mental health center (as described in section 1861(ff)(2)(B)).”.

(2) Section 1866(e) of such Act (42 U.S.C. 1395cc(e))¹⁶ is amended by striking “include a clinic” and all that follows through the period and inserting the following: “include—

“(1) a clinic, rehabilitation agency, or public health agency if, in the case of a clinic or rehabilitation agency, such clinic or agency meets the requirements of section 1861(p)(4)(A) (or meets the requirements of such section through the operation of section 1861(g)), or if, in the case of a public health agency, such agency meets the requirements of section 1861(p)(4)(B) (or meets the requirements of such section through the operation of section 1861(g)), but only with respect to the furnishing of outpatient physical therapy services (as therein defined) or (through the operation of section 1861(g)) with respect to the furnishing of outpatient occupational therapy services; and

“(2) a community mental health center (as defined in section 1861(ff)(3)(B)), but only with respect to the furnishing of partial hospitalization services (as described in section 1861(ff)(1)).”.

(c) **EFFECTIVE DATE.**—The amendments made by subsections (a) and (b) shall apply with respect to partial hospitalization services provided on or after October 1, 1991.

SEC. 4163. COVERAGE OF SCREENING MAMMOGRAPHY.

(a) **IN GENERAL.**—Section 1861 of the Social Security Act (42 U.S.C. 1395x) is amended—

(1) in subsection (s)—

(A) in paragraph (11), by striking all that follows “(bb))” and inserting a semicolon,

(B) in paragraph (12)(C), by striking all that follows “area)” and inserting “; and”, and

(C) by inserting after paragraph (12) the following new paragraph:

42 USC 1395k
note.

¹⁶ So in original. Probably should be “(e))”.

“(13) screening mammography (as defined in subsection (jj));”;
and
(2) by inserting after subsection (ii) the following new subsection:

“Screening Mammography

“(jj) The term ‘screening mammography’ means a radiologic procedure provided to a woman for the purpose of early detection of breast cancer and includes a physician’s interpretation of the results of the procedure.”.

(b) PAYMENT AND COVERAGE.—Section 1834 of such Act (42 U.S.C. 1395m) is amended—

(1) in subsection (b)(1)(B), by inserting “and subject to subsection (c)(1)(A)” after “conversion factors”, and

(2) by inserting after subsection (b) the following new subsection:

“(c) PAYMENTS AND STANDARDS FOR SCREENING MAMMOGRAPHY.—

“(1) IN GENERAL.—Notwithstanding any other provision of this part, with respect to expenses incurred for screening mammography (as defined in section 1861(jj))—

“(A) payment may be made only for screening mammography conducted consistent with the frequency permitted under paragraph (2);

“(B) payment may be made only if the screening mammography meets the quality standards established under paragraph (3); and

“(C) the amount of the payment under this part shall, subject to the deductible established under section 1833(b), be equal to 80 percent of the least of—

“(i) the actual charge for the screening,

“(ii) the fee schedule established under subsection (b) or the fee schedule established under section 1848, whichever is applicable, with respect to both the professional and technical components of the screening mammography, or

“(iii) the limit established under paragraph (4) for the screening mammography.

“(2) FREQUENCY COVERED.—

“(A) IN GENERAL.—Subject to revision by the Secretary under subparagraph (B)—

“(i) No payment may be made under this part for screening mammography performed on a woman under 35 years of age.

“(ii) Payment may be made under this part for only 1 screening mammography performed on a woman over 34 years of age, but under 40 years of age.

“(iii) In the case of a woman over 39 years of age, but under 50 years of age, who—

“(I) is at a high risk of developing breast cancer (as determined pursuant to factors identified by the Secretary), payment may not be made under this part for a screening mammography performed within the 11 months following the month in which a previous screening mammography was performed, or

“(II) is not at a high risk of developing breast cancer, payment may not be made under this part for a screening mammography performed within the 23 months following the month in which a previous screening mammography was performed.

“(iv) In the case of a woman over 49 years of age, but under 65 years of age, payment may not be made under this part for screening mammography performed within 11 months following the month in which a previous screening mammography was performed.

“(v) In the case of a woman over 64 years of age, payment may not be made for screening mammography performed within 23 months following the month in which a previous screening mammography was performed.

“(B) REVISION OF FREQUENCY.—

“(i) REVIEW.—The Secretary, in consultation with the Director of the National Cancer Institute, shall review periodically the appropriate frequency for performing screening mammography, based on age and such other factors as the Secretary believes to be pertinent.

“(ii) REVISION OF FREQUENCY.—The Secretary, taking into consideration the review made under clause (i), may revise from time to time the frequency with which screening mammography may be paid for under this subsection, but no such revision shall apply to screening mammography performed before January 1, 1992.

“(3) QUALITY STANDARDS.—The Secretary shall establish standards to assure the safety and accuracy of screening mammography performed under this part. Such standards shall include the requirements that—

“(A) the equipment used to perform the mammography must be specifically designed for mammography and must meet radiologic standards established by the Secretary for mammography;

“(B) the mammography must be performed by an individual who—

“(i) is licensed by a State to perform radiological procedures, or

“(ii) is certified as qualified to perform radiological procedures by such an appropriate organization as the Secretary specifies in regulations;

“(C) the results of the mammography must be interpreted by a physician—

“(i) who is certified as qualified to interpret radiological procedures by such an appropriate board as the Secretary specifies in regulations, or

“(ii) who is certified as qualified to interpret screening mammography procedures by such a program as the Secretary recognizes in regulation as assuring the qualifications of the individual with respect to such interpretation; and

“(D) with respect to the first screening mammography performed on a woman for which payment is made under this part, there are satisfactory assurances that the results of the mammography will be placed in permanent medical records maintained with respect to the woman.

“(4) LIMIT.—

“(A) \$55, INDEXED.—Except as provided by the Secretary under subparagraph (B), the limit established under this paragraph—

“(i) for screening mammography performed in 1991, is \$55, and

“(ii) for screening mammography performed in a subsequent year is the limit established under this paragraph for the preceding year increased by the percentage increase in the MEI for that subsequent year.

“(B) REDUCTION OF LIMIT.—The Secretary shall review from time to time the appropriateness of the amount of the limit established under this paragraph. The Secretary may, with respect to screening mammography performed in a year after 1992, reduce the amount of such limit as it applies nationally or in any area to the amount that the Secretary estimates is required to assure that screening mammography of an appropriate quality is readily and conveniently available during the year.

“(C) APPLICATION OF LIMIT IN HOSPITAL OUTPATIENT SETTING.—The Secretary shall provide for an appropriate allocation of the limit established under this paragraph between professional and technical components in the case of hospital outpatient screening mammography (and comparable situations) where there is a claim for professional services separate from the claim for the radiologic procedure.

“(5) LIMITING CHARGES OF NONPARTICIPATING PHYSICIANS.—

“(A) IN GENERAL.—In the case of mammography screening performed on or after January 1, 1991, for which payment is made under this subsection, if a nonparticipating physician or supplier provides the screening to an individual entitled to benefits under this part, the physician or supplier may not charge the individual more than the limiting charge (as defined in subparagraph (B), or if less, as defined in subsection (b)(5)(B) or as defined in section 1848(g)(2)).

“(B) LIMITING CHARGE DEFINED.—In subparagraph (A), the term ‘limiting charge’ means, with respect to screening mammography performed—

“(i) in 1991, 125 percent of the limit established under paragraph (4),

“(ii) in 1992, 120 percent of the limit established under paragraph (4), or

“(iii) after 1992, 115 percent of the limit established under paragraph (4).

“(C) ENFORCEMENT.—If a physician or supplier knowing and willfully imposes a charge in violation of subparagraph (A), the Secretary may apply sanctions against such physician or supplier in accordance with section 1842(j)(2).”.

(c) CERTIFICATION OF SCREENING MAMMOGRAPHY QUALITY STANDARDS.—

(1) Section 1863 of such Act (42 U.S.C. 1395z) is amended by inserting “or whether screening mammography meets the standards established under section 1834(c)(3),” after “1832(a)(2)(F)(i),”.

(2) The first sentence of section 1864(a) of such Act (42 U.S.C. 1395aa(a)) is amended by inserting before the period the following: “, or whether screening mammography meets the standards established under section 1834(c)(3)”.

(3) Section 1865(a) of such Act (42 U.S.C. 1395bb(a)) is amended by inserting “1834(c)(3),” after “1832(a)(2)(F)(i),”

(d) CONFORMING AMENDMENTS.—

(1) Section 1833(a)(2)(E) of such Act (42 U.S.C. 1395l(a)(2)(E)) is amended by inserting “, but excluding screening mammography” after “imaging services”.

(2) Section 1862(a) of such Act (42 U.S.C. 1395y(a)) is amended—

(A) in paragraph (1)—

(i) in subparagraph (A), by striking “subparagraph (B), (C), (D), or (E)” and inserting “a succeeding subparagraph”,

(ii) in subparagraph (D), by striking “and” at the end,

(iii) in subparagraph (E), by striking the semicolon at the end and inserting “, and”, and

(iv) by adding at the end the following new subparagraph:

“(F) in the case of screening mammography, which is performed more frequently than is covered under section 1834(c)(2) or which does not meet the standards established under section 1834(c)(3), and, in the case of screening pap smear, which is performed more frequently than is provided under section 1861(nn);” and

(B) in paragraph (7), by inserting “or under paragraph (1)(F)” after “(1)(B)”.

42 USC 1395l
note.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to screening mammography performed on or after January 1, 1991.

SEC. 4164. MISCELLANEOUS AND TECHNICAL PROVISIONS RELATING TO PART B.

(a) EXTENSION OF DEMONSTRATIONS.—

42 USC 1395b-1
note.

(1) PREVENTION DEMONSTRATIONS.—Section 9314 of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended by section 9344 of the Omnibus Budget Reconciliation Act of 1986, is amended—

(A) in subsection (a), by striking “4-year” and inserting “5-year”;

(B) in subsection (e)(2), by striking “Not later than five years after the date of the enactment of this Act, the Secretary shall submit a final report” and inserting “Not later than April 1, 1993, the Secretary shall submit an interim report”;

(C) in subsection (e), by adding at the end the following new paragraph:

“(3) Not later than April 1, 1995, the Secretary shall submit a final report to those Committees on the demonstration program and shall include in the report a comprehensive evaluation of the long-term effects of the program.”¹⁷;

(D) in subsection (f), by striking “\$5,900,000” and inserting “\$7,500,000”; and

¹⁷ So in original. Probably should be “program.”;

(E) in subsection (f), by inserting before the period at the end the following: “and shall not exceed \$3,000,000 for the comprehensive evaluation referred to in subsection (e)(3)”.

(2) ALZHEIMER’S DISEASE DEMONSTRATION PROJECTS.—Section 9342 of the Omnibus Budget Reconciliation Act of 1986 is amended—

42 USC 1395b-1
note.

(A) in subsection (c)(1), by striking “3 years” and inserting “4 years”;

(B) in subsection (d)(1), by striking “third year” and inserting “fourth year”;

(C) in subsection (f)—

(i) by striking “\$40,000,000” and inserting “\$55,000,000”, and

(ii) by striking “\$2,000,000” and inserting “\$3,000,000”.

(b) DISCLOSURE OF OWNERSHIP.—

(1) IN GENERAL.—Title XI of the Social Security Act is amended by inserting after section 1124 the following new section:

“DISCLOSURE REQUIREMENTS FOR OTHER PROVIDERS UNDER PART B OF
MEDICARE

“SEC. 1124A. (a) DISCLOSURE REQUIRED TO RECEIVE PAYMENT.—No payment may be made under part B of title XVIII for items or services furnished by any disclosing part B provider unless such provider has provided the Secretary with full and complete information—

42 USC 1320a-3.

“(1) on the identity of each person with an ownership or control interest in the provider or in any subcontractor (as defined by the Secretary in regulations) in which the provider directly or indirectly has a 5 percent or more ownership interest; and

“(2) with respect to any person identified under paragraph (1) or any managing employee of the provider—

“(A) on the identity of any other entities providing items or services for which payment may be made under title XVIII of the Social Security Act with respect to which such person or managing employee is a person with an ownership or control interest at the time such information is supplied or at any time during the 3-year period ending on the date such information is supplied, and

“(B) as to whether any penalties, assessments, or exclusions have been assessed against such person or managing employee under section 1128, 1128A, or 1128B.

“(b) UPDATES TO INFORMATION SUPPLIED.—A disclosing part B provider shall notify the Secretary of any changes or updates to the information supplied under subsection (a) not later than 180 days after such changes or updates take effect.

“(c) DEFINITIONS.—For purposes of this section—

“(1) the term ‘disclosing part B provider’ means any entity receiving payment on an assignment-related basis for furnishing items or services for which payment may be made under part B of title XVIII, except that such term does not include an entity described in section 1124(a)(2);

“(2) the term ‘managing employee’ means, with respect to a provider, a person described in section 1126(b); and

“(3) the term ‘person with an ownership or control interest’ means, with respect to a provider—

“(A) a person described in section 1124(a)(3), or

“(B) a person who has one of the 5 largest direct or indirect ownership or control interests in the provider.”.

(2) CRIMINAL PENALTY FOR PROVIDING FALSE INFORMATION.—Section 1128B(c) of such Act (42 U.S.C. 1320a-7b(c)) is amended by striking “health care program” and inserting “health care program, or with respect to information required to be provided under section 1124A,”.

(3) FAILURE TO PROVIDE INFORMATION AS GROUNDS FOR PERMISSIVE EXCLUSION FROM PROGRAM.—Section 1128(b)(9) of such Act (42 U.S.C. 1320a-7(b)(9)) is amended by striking “1124” and inserting “1124, section 1124A,”.

42 USC 1320a-3a
note.

(4) EFFECTIVE DATE.—The amendments made by paragraph (1), (2), and (3) shall apply with respect to items or services furnished on or after—

(A) January 1, 1993, in the case of items or services furnished by a provider who, on or before the date of the enactment of this Act, has furnished items or services for which payment may be made under part B of title XVIII of the Social Security Act; or

(B) January 1, 1992, in the case of items or services furnished by any other provider.

42 USC 1395u
note.

(c) DIRECTORY OF UNIQUE PHYSICIAN IDENTIFIER NUMBERS.—Not later than March 31, 1991, the Secretary of Health and Human Services shall publish a directory of the unique physician identification numbers of all physicians providing services for which payment may be made under part B of title XVIII of the Social Security Act, and shall include in such directory the names, provider numbers, and billing addressess of all listed physicians.

PART 3—PROVISIONS RELATING TO PARTS A AND B

SEC. 4201. PROVISIONS RELATING TO END STAGE RENAL DISEASE.

42 USC 1395rr
note.

(a) INCREASE IN COMPOSITE RATES.—Section 9335(a)(1) of the Omnibus Budget Reconciliation Act of 1986, as amended by section 6203(a)(1) of the Omnibus Budget Reconciliation Act of 1989, is amended—

(1) by striking “October 1, 1990,” and inserting “December 31, 1990,”; and

(2) by inserting after the first sentence the following: “With respect to services furnished on or after January 1, 1991, such base rate shall be equal to the respective rate in effect as of September 30, 1990 (determined without regard to any reductions imposed pursuant to section 6201 of the Omnibus Budget Reconciliation Act of 1989), increased by \$1.00.”.

42 USC 1395rr
note.

(b) PROPAC STUDY ON ESRD COMPOSITE RATES.—

(1) IN GENERAL.—

(A) STUDY.—The Prospective Payment Assessment Commission (in this subsection referred to as the “Commission”) shall conduct a study to determine the costs and services and profits associated with various modalities of dialysis treatments provided to end stage renal disease

patients provided under title XVIII of the Social Security Act.

(B) **RECOMMENDATIONS.**—Based on information collected for the study described in subparagraph (A), the Commission shall make recommendations to Congress regarding the method or methods and the levels at which the payments made for the facility component of dialysis services by providers of service and renal dialysis facilities under title XVIII of the Social Security Act should be established for dialysis services furnished during fiscal year 1993 and the methodology to be used to update such payments for subsequent fiscal years. In making recommendations concerning the appropriate methodology the Commission shall consider—

- (i) hemodialysis and other modalities of treatment,
- (ii) the appropriate services to be included in such payments,
- (iii) the adjustment factors to be incorporated including facility characteristics, such as hospital versus free-standing facilities, urban versus rural, size and mix of services,
- (iv) adjustments for labor and nonlabor costs,
- (v) comparative profit margins for all types of renal dialysis providers of service and renal dialysis facilities,
- (vi) adjustments for patient complexity, such as age, diagnosis, case mix, and pediatric services, and
- (vii) efficient costs related to high quality of care and positive outcomes for all treatment modalities.

(2) **REPORT.**—Not later than June 1, 1992, the Commission shall submit a report to the Committee on Finance of the Senate, and the Committees on Ways and Means and Energy and Commerce of the House of Representatives on the study conducted under paragraph (1)(A) and shall include in the report the recommendations described in paragraph (1)(B), taking into account the factors described in paragraph (1)(B).

(3) **ANNUAL REPORT.**—The Commission, not later than March 1 before the beginning of each fiscal year (beginning with fiscal year 1993) shall report its recommendations to the Committee on Finance of the Senate and the Committees on Ways and Means and Energy and Commerce of the House of Representatives on an appropriate change factor which should be used for updating payments for services rendered in that fiscal year. The Commission in making such report to Congress shall consider conclusions and recommendations available from the Institute of Medicine.

(c) **PAYMENT RATES FOR ERYTHROPOIETIN.**—

(1) **IN GENERAL.**—Section 1881(b)(11) of the Social Security Act (42 U.S.C. 1395rr(b)) is amended—

(A) by striking “(11)” and inserting “(11)(A)”; and

(B) by adding at the end the following new subparagraph:

“(B) Erythropoietin, when provided to a patient determined to have end stage renal disease, shall not be included as a dialysis service for purposes of payment under any prospective payment amount or comprehensive fee established under this section, and payment for such item shall be made separately—

“(i) in the case of erythropoietin provided by a physician, in accordance with section 1833; and

“(ii) in the case of erythropoietin provided by a provider of services, renal dialysis facility, or other supplier of home dialysis supplies and equipment—

“(I) for erythropoietin provided during 1991, in an amount equal to \$11 per thousand units (rounded to the nearest 100 units), and

“(II) for erythropoietin provided during a subsequent year, in an amount determined to be appropriate by the Secretary, except that such amount may not exceed the amount determined under this clause for the previous year increased by the percentage increase (if any) in the implicit price deflator for gross national product (as published by the Department of Commerce) for the second quarter of the preceding year over the implicit price deflator for the second quarter of the second preceding year.”.

42 USC 1395rr
note.

(2) **EFFECTIVE DATE.**—The amendments made by paragraph (1) shall apply to erythropoietin furnished on or after January 1, 1991.

(d) **SELF-ADMINISTERED ERYTHROPOIETIN.**—

(1) **COVERAGE.**—Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)) as amended by section 4156(a)(1), is amended—

(A) by striking “and” at the end of subparagraph (N);

(B) by adding “and” at the end of subparagraph (O); and

(C) by adding at the end the following new subparagraph:

“(P) erythropoietin for home dialysis patients competent to use such drug without medical or other supervision with respect to the administration of such drug, subject to methods and standards established by the Secretary by regulation for the safe and effective use of such drug, and items related to the administration of such drug;”.

(2) **COVERAGE FOR METHOD II PATIENTS.**—Section 1881(b) (42 U.S.C. 1395rr(b)) is further amended—

(A) in paragraph (1)—

(B) by striking “and (B)” and inserting “(B),¹⁸ and

(C) by striking “equipment.” and inserting “equipment, and (C) payments to a supplier of home dialysis supplies and equipment that is not a provider of services, a renal dialysis facility, or a physician for self-administered erythropoietin as described in section 1861(s)(2)(Q) if the Secretary finds that the patient receiving such drug from such a supplier can safely and effectively administer the drug (in accordance with the applicable methods and standards established by the Secretary pursuant to such section).”; and

(3) by adding at the end of paragraph (11), as amended by subsection (c), the following new subparagraph:

“(C) The amount payable to a supplier of home dialysis supplies and equipment that is not a provider of services, a renal dialysis facility, or a physician for erythropoietin shall be determined in the same manner as the amount payable to a renal dialysis facility for such item.”.

42 USC 1395x
note.

(3) **EFFECTIVE DATE.**—The amendments made by paragraphs (1) and (2) shall apply to items and services furnished on or after July 1, 1991.

42 USC 1395rr
note.

SEC. 4202. STAFF-ASSISTED HOME DIALYSIS DEMONSTRATION PROJECT.

(a) **ESTABLISHMENT.**—

¹⁸ So in original. Probably should be ““(B)”,”.

(1) **IN GENERAL.**—Not later than 9 months after the date of the enactment of this Act, the Secretary of Health and Human Services shall establish and carry out a 3-year demonstration project to determine whether the services of a home dialysis staff assistant providing services to a patient during hemodialysis treatment at the patient's home may be covered under the medicare program in a cost-effective manner that ensures patient safety.

(2) **NUMBER OF PARTICIPANTS.**—The total number of eligible patients receiving services under the demonstration project established under paragraph (1) may not exceed 800.

(b) PAYMENTS TO PARTICIPATING PROVIDERS AND FACILITIES.—

(1) SERVICES FOR WHICH PAYMENT MAY BE MADE.—

(A) **IN GENERAL.**—Under the demonstration project established under subsection (a), the Secretary shall make payments for 3 years under title XVIII of the Social Security Act to providers of services (other than a skilled nursing facility) or renal dialysis facilities for services of a home hemodialysis staff assistant provided to an individual described in subsection (c) during hemodialysis treatment at the individual's home in an amount determined under paragraph (2).

(B) **SERVICES DESCRIBED.**—For purposes of subparagraph (A), the term “services of a home hemodialysis staff assistant” means—

- (i) technical assistance with the operation of a hemodialysis machine in the patient's home and with such patient's care during in-home hemodialysis; and
- (ii) administration of medications within the patient's home to maintain the patency of the extra corporeal circuit.

(2) AMOUNT OF PAYMENT.—

(A) **IN GENERAL.**—Payment to a provider of services or renal dialysis facility participating in the demonstration project established under subsection (a) for the services described in paragraph (1) shall be prospectively determined by the Secretary, made on a per treatment basis, and shall be in an amount determined under subparagraph (B).

(B) **DETERMINATION OF PAYMENT AMOUNT.**—(i) The amount of payment made under subparagraph (A) shall be the product of—

(I) the rate determined under clause (ii) with respect to a provider of services or a renal dialysis facility; and

(II) the factor by which the labor portion of the composite rate determined under section 1881(b)(7) of the Social Security Act is adjusted for differences in area wage levels.

(ii) The rate determined under this clause, with respect to a provider of services or renal dialysis facility, shall be equal to the difference between—

(I) two-thirds of the labor portion of the composite rate applicable under section 1881(b)(7) of such Act to the provider or facility (as adjusted to reflect differences in area wage levels), and

(II) the product of the national median hourly wage for a home hemodialysis staff assistant and the national median time expended in the provision of home

hemodialysis staff assistant services (taking into account time expended in travel and predialysis patient care).

(iii) For purposes of clause (ii)(II)—

(I) the national median hourly wage for a home hemodialysis staff assistant and the national median average time expended for home hemodialysis staff assistant services shall be determined annually on the basis of the most recent data available, and

(II) the national median hourly wage for a home hemodialysis staff assistant shall be the sum of 65 percent of the national median hourly wage for a licensed practical nurse and 35 percent of the national median hourly wage for a registered nurse.

(C) PAYMENT AS ADD-ON TO COMPOSITE RATE.—The amount of payment determined under this paragraph shall be in addition to the amount of payment otherwise made to the provider of services or renal dialysis facility under section 1881(b) of such Act.

(c) INDIVIDUALS ELIGIBLE TO RECEIVE SERVICES UNDER PROJECT.—

(1) IN GENERAL.—An individual may receive services from a provider of services or renal dialysis facility participating in the demonstration project if—

(A) the individual is not a resident of a skilled nursing facility;

(B) the individual is an end stage renal disease patient entitled to benefits under title XVIII of the Social Security Act;

(C) the individual's physician certifies that the individual is confined to a bed or wheelchair and cannot transfer themselves from a bed to a chair;

(D) the individual has a serious medical condition (as specified by the Secretary) which would be exacerbated by travel to and from a dialysis facility;

(E) the individual is eligible for ambulance transportation to receive routine maintenance dialysis treatments, and, based on the individual's medical condition, there is reasonable expectation that such transportation will be used by the individual for a period of at least 6 consecutive months, such that the cost of ambulance transportation can reasonably be expected to meet or exceed the cost of home hemodialysis staff assistance as provided under subsection (b)(4); and

(F) no family member or other individual is available to provide such assistance to the individual.

(2) COVERAGE OF INDIVIDUALS CURRENTLY RECEIVING SERVICES.—Any individual who, on the date of the enactment of this Act, is receiving staff assistance under the experimental authority provided under section 1881(f)(2) of the Social Security Act shall be deemed to be an eligible individual for purposes of this subsection.

(3) CONTINUATION OF COVERAGE UPON TERMINATION OF PROJECT.—Notwithstanding any provision of title XVIII of the Social Security Act, any individual receiving services under the demonstration project established under subsection (a) as of the date of the termination of the project shall continue to be eligible for home hemodialysis staff assistance after such date

under such title on the same terms and conditions as applied under the demonstration project.

(d) **QUALIFICATIONS FOR HOME HEMODIALYSIS STAFF ASSISTANTS.**—For purposes of subsection (b), a home dialysis aide is qualified if the aide—

(1) meets minimum qualifications as specified by the Secretary; and

(2) meets any applicable qualifications as specified under the law of the State in which the home hemodialysis staff assistant is providing services.

(e) **REPORTS.**—

(1) **INTERIM STATUS REPORT.**—Not later than December 1, 1992, the Secretary shall submit to Congress a preliminary report on the status of the demonstration project established under subsection (a).

(2) **FINAL REPORT.**—Not later than December 31, 1995, the Secretary shall submit to Congress a final report evaluating the project, and shall include in such report recommendations regarding appropriate eligibility criteria and cost-control mechanisms for medicare coverage of the services of a home dialysis aide providing medical assistance to a patient during hemodialysis treatment at the patient's home.

(f) **AUTHORIZATION OF APPROPRIATIONS.**—The Secretary shall provide for the transfer from the Federal Supplementary Medical Insurance Trust Fund (established under section 1841 of the Social Security Act) of not more than the following amounts to carry out the demonstration project established under subsection (a) (without regard to amounts appropriated in advance in appropriation Acts):

(1) For fiscal year 1991, \$4,000,000.

(2) For fiscal year 1992, \$4,000,000.

(3) For fiscal year 1993, \$3,000,000.

(4) For fiscal year 1994, \$2,000,000.

(5) For fiscal year 1995, \$1,000,000.

SEC. 4203. EXTENSION OF SECONDARY PAYOR PROVISIONS.

(a) **EXTENSION OF TRANSFER OF DATA.**—

(1) Section 1862(b)(5)(C)(iii) (42 U.S.C. 1395y(b)(5)(C)(iii)) is amended by striking “September 30, 1991” and inserting “September 30, 1995”.

(2) Section 6103(l)(12)(F) of the Internal Revenue Code of 1986 26 USC 6103. is amended—

(A) in clause (i), by striking “September 30, 1991” and inserting “September 30, 1995”;

(B) in clause (ii)(I), by striking “1990” and inserting “1994”; and

(C) in clause (ii)(II), by striking “1991” and inserting “1995”.

(b) **EXTENSION OF APPLICATION TO DISABLED BENEFICIARIES.**—Section 1862(b)(1)(B)(iii) (42 U.S.C. 1395y(b)(1)(B)(iii)) is amended by striking “January 1, 1992” and inserting “October 1, 1995”

(c) **INDIVIDUALS WITH END STAGE RENAL DISEASE.**—

(1) **IN GENERAL.**—Section 1862(b)(1)(C) (42 U.S.C. 1395y(b)(1)(C)) is amended—

(A) in clause (i), by striking “during the 12-month period” and all that follows and inserting “during the 12-month period which begins with the first month in which the individual becomes entitled to benefits under part A under

the provisions of section 226A, or, if earlier, the first month in which the individual would have been entitled to benefits under such part under the provisions of section 226A if the individual had filed an application for such benefits; and”

(B) in the matter following clause (ii), by adding at the end the following: “Effective for items and services furnished on or after February 1, 1991, and on or before January 1, 1996, (with respect to periods beginning on or after February 1, 1990), clauses (i) and (ii) shall be applied by substituting ‘18-month’ for ‘12-month’ each place it appears.”.

42 USC 1395y
note.

(2) GAO STUDY OF EXTENSION OF SECONDARY PAYER PERIOD.—

(A) The Comptroller General shall conduct a study of the impact of the application of clause (iii) of section 1862(b)(1)(C) of the Social Security Act on individuals entitled to benefits under title XVIII of such Act by reason of section 226A of such Act, and shall include in such report information relating to—

(i) the number (and geographic distribution) of such individuals for whom medicare is secondary;

(ii) the amount of savings to the medicare program achieved annually by reason of the application of such clause;

(iii) the effect on access to employment, and employment-based health insurance, for such individuals and their family members (including coverage by employment-based health insurance of cost-sharing requirements under medicare after such employment-based insurance becomes secondary);

(iv) the effect on the amount paid for each dialysis treatment under employment-based health insurance;

(v) the effect on cost-sharing requirements under employment-based health insurance (and on out-of-pocket expenses of such individuals) during the period for which medicare is secondary;

(vi) the appropriateness of applying the provisions of section 1862(b)(1)(C) to all group health plans.

(B) The Comptroller General shall submit a preliminary report on the study conducted under subparagraph (A) to the Committees on Ways and Means and Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate not later than January 1, 1993, and a final report on such study not later than January 1, 1995.

(d) EFFECTIVE DATE.—The amendments made this subsection shall take effect on the date of the enactment of this Act and the amendment made by subsection (a)(2)(B) shall apply to requests made on or after such date.

SEC. 4204. HEALTH MAINTENANCE ORGANIZATIONS.

(a) REGULATION OF INCENTIVE PAYMENTS TO PHYSICIANS.—

(1) IN GENERAL.—Section 1876(i) (42 U.S.C. 1395mm(i)) is amended by adding at the end the following new paragraph: “(8)(A) Each contract with an eligible organization under this section shall provide that the organization may not operate any physician incentive plan (as defined in subparagraph (B)) unless the following requirements are met:

“(i) No specific payment is made directly or indirectly under the plan to a physician or physician group as an inducement to

26 USC 6103
note.

reduce or limit medically necessary services provided with respect to a specific individual enrolled with the organization.

“(ii) If the plan places a physician or physician group at substantial financial risk (as determined by the Secretary) for services not provided by the physician or physician group, the organization—

“(I) provides stop-loss protection for the physician or group that is adequate and appropriate, based on standards developed by the Secretary that take into account the number of physicians placed at such substantial financial risk in the group or under the plan and the number of individuals enrolled with the organization who receive services from the physician or the physician group, and

“(II) conducts periodic surveys of both individuals enrolled and individuals previously enrolled with the organization to determine the degree of access of such individuals to services provided by the organization and satisfaction with the quality of such services.

“(iii) The organization provides the Secretary with descriptive information regarding the plan, sufficient to permit the Secretary to determine whether the plan is in compliance with the requirements of this subparagraph.

“(B) In this paragraph, the term ‘physician incentive plan’ means any compensation arrangement between an eligible organization and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services provided with respect to individuals enrolled with the organization.”.

(2) **PENALTIES.**—Section 1876(i)(6)(A)(vi) (42 U.S.C. 1395mm(i)(6)(A)(vi)) is amended by striking “(g)(6)(A);” and inserting “(g)(6)(A) or paragraph (8);”.

(3) **REPEAL OF PROHIBITION.**—Section 1128A(b)(1) (42 U.S.C. 1320a-7a(b)(1)) is amended—

(A) by striking “, an eligible organization” and all that follows through “section 1876,”

(B) by adding “and” at the end of subparagraph (A),

(C) by striking subparagraph (B),

(D) by redesignating subparagraph (C) as subparagraph (B), and

(E) by striking “or organization”.

(4) **EFFECTIVE DATE.**—The amendments made by paragraphs (1) and (2) shall apply with respect to contract years beginning on or after January 1, 1992, and the amendments made by paragraph (3) shall take effect on the date of the enactment of this Act. 42 USC 1395mm note.

(b) **REQUIREMENTS WITH RESPECT TO ACTUARIAL EQUIVALENCE OF AAPCC.**—(1) Not later than January 1, 1992, the Secretary of Health and Human Services (in this section referred to as the “Secretary”) shall submit a proposal to Congress that provides for a modified payment method for organizations with a risk contract under section 1876(g) of the Social Security Act that is more accurate than the current payment methodology in predicting the actual service utilization and annual medical expenditures of the beneficiary population enrolled in a specific organization. 42 USC 1395mm note.

(2) The proposal shall include—

(A)(i) recommendations on modifying the current adjusted average per capita cost formula, by adding predictors of medical

utilization such as health status adjustors or prior utilization measures; or

(ii) recommendations for a new payment methodology as an alternative to the adjusted average per capita cost;

(B) data to support any recommended changes in payment methodology for organizations with risk contracts under section 1876(g) of the Social Security Act; and

(C) analysis demonstrating that any proposed or revised payment methodology under this section is effective in explaining at least 15 percent of the variation in health care utilization and costs (as determined in consultation with the American Academy of Actuaries) among individuals enrolled in such organizations.

(3) Not later than March 1, 1992, the Secretary shall cause to have published in the Federal Register a proposed rule providing for the implementation of the payment methodology specified in the proposal submitted pursuant to paragraph (1).

(4) Not later than May 1, 1992, the Comptroller General shall review the proposal and recommendations made pursuant to paragraphs (1) and (2), and shall report to Congress on appropriate modifications in such payment methodology.

(5) Taking into account the recommendations made pursuant to paragraph (4), on or after August 1, 1992, the Secretary shall issue a final rule implementing a payment methodology that meets the requirements of paragraph (1), effective for contract years beginning on or after January 1, 1993.

(c) APPLICATION OF NATIONAL COVERAGE DECISIONS.—

(1) IN GENERAL.—Section 1876(c)(2) (42 U.S.C. 1395mm(c)(2)) is amended—

(A) by redesignating clauses (i) and (ii) and subparagraphs (A) and (B) as subclauses (I) and (II) and clauses (i) and (ii), respectively;

(B) by inserting “(A)” after “(2)”; and

(C) by adding at the end the following new subparagraph:

“(B) If there is a national coverage determination made in the period beginning on the date of an announcement under subsection (a)(1)(A) and ending on the date of the next announcement under such subsection that the Secretary projects will result in a significant¹⁹ change in the costs to the organization of providing the benefits that are the subject of such national coverage determination and that was not incorporated in the determination of the per capita rate of payment included in the announcement made at the beginning of such period—

“(i) such determination shall not apply to risk-sharing contracts under this section until the first contract year that begins after the end of such period; and

“(ii) if such coverage determination provides for coverage of additional benefits or under additional circumstances, subsection (a)(3) shall not apply to payment for such additional benefits or benefits provided under such additional circumstances until the first contract year that begins after the end of such period,

unless otherwise required by law.”.

(2) CONFORMING AMENDMENT.—Section 1876(a)(6) of such Act is amended by striking “subsection (c)(7)” and inserting “subsections (c)(2)(B)(ii) and (c)(7)”.

¹⁹ So in original. Probably should be “significant”.

(3) **EFFECTIVE DATE.**—The amendments made by this subsection shall apply with respect to national coverage determinations that are not incorporated in the determination of the per capita rate of payment for individuals enrolled for 1991 with an eligible organization which has entered into a risk-sharing contract under section 1876 of the Social Security Act.

42 USC 1395mm
note.

(d) **PAYMENTS FOR SERVICES FURNISHED BY NON-CONTRACT PROVIDERS.**—

(1) **IN GENERAL.**—Section 1876(j) (42 U.S.C. 1395mm(j)) is amended—

(A) in paragraph (1)(A)—

(i) by striking “physician” each place it appears and inserting “physician or provider of services or renal dialysis facility”,

(ii) by striking “physicians’ services” and inserting “physicians’ services or renal dialysis services”, and

(iii) by striking “participation agreement under section 1842(h)(1)” and inserting “applicable participation agreement”,

(B) in paragraph (2)—

(i) by striking “physicians’ services” each place it appears and inserting “physicians’ services or renal dialysis services”, and

(ii) by striking “which—” and all that follows and inserting “which are furnished to an enrollee of an eligible organization under this section²⁰ by a physician, provider of services, or renal dialysis facility who is not under a contract with the organization.”.

(2) **EFFECTIVE DATE.**—The amendment made by paragraph (1) shall apply with respect to items and services furnished on or after January 1, 1991.

42 USC 1395mm
note.

(e) **RETROACTIVE ENROLLMENT.**—

(1) **IN GENERAL.**—Section 1876(a)(1)(E) (42 U.S.C. 1395mm(a)(1)(E)) is amended—

(A) by striking “(E)” and inserting “(E)(i)”; and

(B) by adding at the end the following new clause:

“(ii)(I) Subject to subclause (II), the Secretary may make retroactive adjustments under clause (i) to take into account individuals enrolled during the period beginning on the date on which the individual enrolls with an eligible organization (which has a risk-sharing contract under this section) under a health benefit plan operated, sponsored, or contributed to, by the individual’s employer or former employer (or the employer or former employer of the individual’s spouse) and ending on the date on which the individual is enrolled in the plan under this section, except that for purposes of making such retroactive adjustments under this clause, such period may not exceed 90 days.

“(II) No adjustment may be made under subclause (I) with respect to any individual who does not certify that the organization provided the individual with the explanation described in subsection (c)(3)(E) at the time the individual enrolled with the organization.”.

(2) **EFFECTIVE DATE.**—The amendments made by paragraph (1) shall apply with respect to individuals enrolling with an eligible organization (which has a risk-sharing contract under section 1876 of the Social Security Act) under a health benefit plan operated, sponsored, or contributed to, by the individual’s em-

42 USC 1395mm
note.

²⁰ So in original. Probably should be “section”.

42 USC 1395mm
note.

ployer or former employer (or the employer or former employer of the individual's spouse) on or after January 1, 1991.

(f) STUDY OF CHIROPRACTIC SERVICES.—

(1) The Secretary shall conduct a study of the extent to which health maintenance organizations with contracts under section 1876 of the Social Security Act make available to enrollees entitled to benefits under title XVIII of such Act chiropractic services that are covered under such title.

(2) The study shall examine the arrangements under which such services are made available and the types of practitioners furnishing such services to such enrollees.

(3) The study shall be based on contracts entered into or renewed on or after January 1, 1991, and before January 1, 1993.

(4) The Secretary shall issue a final report to the Committees on Ways and Means and Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate on the results of the study not later than January 1, 1993. The report shall include recommendations with respect to any legislative and regulatory changes that the Secretary determines are necessary to ensure access to such services.

(g) PROHIBITING CERTAIN EMPLOYER MARKETING ACTIVITIES.—

(1) IN GENERAL.—Section 1862(b)(3) (42 U.S.C. 1395y(b)(3)) is amended by adding at the end the following new subparagraph:

“(C) PROHIBITION OF FINANCIAL INCENTIVES NOT TO ENROLL IN A GROUP HEALTH PLAN.—It is unlawful for an employer or other entity to offer any financial or other incentive for an individual entitled to benefits under this title not to enroll (or to terminate enrollment) under a group health plan which would (in the case of such enrollment) be a primary plan (as defined in paragraph (2)(A)), unless such incentive is also offered to all individuals who are eligible for coverage under the plan. Any entity that violates the previous sentence is subject to a civil money penalty of not to exceed \$5,000 for each such violation. The provisions of section 1128A (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).”.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to incentives offered on or after the date of the enactment of this Act.

42 USC 1395y
note.

SEC. 4205. PEER REVIEW ORGANIZATIONS.

(a) USE OF CORRECTIVE ACTION PLANS.—

(1) IN GENERAL.—Section 1156(b)(1) (42 U.S.C. 1320c-5(b)(1)) is amended—

(A) by inserting “and, if appropriate, after the practitioner or person has been given a reasonable opportunity to enter into and complete a corrective action plan (which may include remedial education) agreed to by the organization, and has failed successfully to complete such plan,” after “concerned,”; and

(B) by inserting after the second sentence the following: “In determining whehter ²¹ a practitioner or person has demonstrated an unwillingness or lack of ability substan-

²¹ So in original. Probably should be “whether”.

tially to comply with such obligations, the Secretary shall consider the practitioner's or person's willingness or lack of ability, during the period before the organization submits its report and recommendations, to enter into and successfully complete a corrective action plan."

(2) **EFFECTIVE DATE.**—The amendments made by paragraph (1) shall apply to initial determinations made by organizations on or after the date of the enactment of this Act.

42 USC 1320c-5
note.

(b) **TREATMENT OF OPTOMETRISTS AND PODIATRISTS.**—

(1) **IN GENERAL.**—Section 1154 (42 U.S.C. 1320c-3) is amended—

(A) in subsection (a)(7)(A)(i), by inserting “, optometry, and podiatry” after “dentistry”; and

(B) in subsection (c), by striking “or dentistry” each place it appears and inserting “dentistry, optometry, or podiatry”.

(2) **EFFECTIVE DATE.**—The amendments made by paragraph (1) shall apply to contracts entered into or renewed on or after the date of the enactment of this Act.

42 USC 1320c-3
note.

(c) **COORDINATION OF PROS AND CARRIERS.**—

(1) **DEVELOPMENT AND IMPLEMENTATION OF PLAN.**—The Secretary of Health and Human Services shall develop and implement a plan to coordinate the physician review activities of peer review organizations and carriers. Such plan shall include—

42 USC 1320c
note.

(A) the development of common utilization and medical review criteria;

(B) criteria for the targetting of reviews by peer review organizations and carriers; and

(C) improved methods for exchange of information among peer review organizations and carriers.

(2) **REPORT.**—Not later than January 1, 1992, the Secretary shall submit to Congress a report on the development of the plan described under paragraph (1) and shall include in the report such recommendations for changes in legislation as may be appropriate.

(d) **PEER REVIEW NOTICE.**—

(1) **NOTICE OF PROPOSED SANCTIONS.**—

(A) **REQUIREMENT.**—Section 1154(a)(9) (42 U.S.C. 1320c-3(a)(9)) is amended—

(i) by inserting “(A)” after “(9)”; and

(ii) by adding at the end the following:

“(B) If the organization finds, after notice and hearing, that a physician has furnished services in violation of this subsection, the organization shall notify the State board or boards responsible for the licensing or disciplining of the physician of its finding and decision.”.

(B) **DISCLOSURE.**—Section 1160(b)(1) (42 U.S.C. 1320c-9(b)(1)) is amended—

(i) by striking “and” at the end of subparagraph (B),

(ii) by adding “and” at the end of subparagraph (C),

and

(iii) by adding at the end the following new subparagraph:

“(D) to provide notice to the State medical board in accordance with section 1154(a)(9)(B) when the organization submits a report and recommendations to the Secretary

under section 1156(b)(1) with respect to a physician whom the board is responsible for licensing;”.

42 USC 1320c-3
note.

(C) **EFFECTIVE DATE.**—The amendments made by this paragraph shall apply to notices of proposed sanctions issued more than 60 days after the date of the enactment of this Act.

(2) **NOTICE TO STATE MEDICAL BOARDS WHEN ADVERSE ACTIONS TAKEN BY SECRETARY.**—

(A) **IN GENERAL.**—Section 1156(b) (42 U.S.C. 1320c-5(b)) is amended by adding at the end the following new paragraph:

“(6) When the Secretary effects an exclusion of a physician under paragraph (2), the Secretary shall notify the State board responsible for the licensing of the physician of the exclusion.”.

42 USC 1320c-5
note.

(B) **EFFECTIVE DATE.**—The amendments made by this paragraph shall apply to sanctions effected more than 60 days after the date of the enactment of this Act.

(e) **CONFIDENTIALITY OF PEER REVIEW DELIBERATIONS.**—

(1) **IN GENERAL.**—Section 1160(d) (42 U.S.C. 1320c-9(d)) is amended by adding at the end the following: “No document or other information produced by such an organization in connection with its deliberations in making determinations under section 1154(a)(1)(B) or 1156(a)(2) shall be subject to subpoena or discovery in any administrative or civil proceeding; except that such an organization shall provide, upon request of a practitioner or other person adversely affected by such a determination, a summary of the organization’s findings and conclusions in making the determination.”.

42 USC 1320c-9
note.

(2) **EFFECTIVE DATE.**—The amendments made by paragraph (1) shall apply to all proceedings as of the date of the enactment of this Act.

(f) **CLARIFICATION OF LIMITATION ON LIABILITY.**—Section 1157(b) (42 U.S.C. 1320c-6(b)) is amended—

(1) by inserting “organization having a contract with the Secretary under this part and no” after “No”,

(2) by striking “by him”, and

(3) by striking “he has exercised due care” and inserting “due care was exercised in the performance of such duty, function, or activity”.

(g) **MISCELLANEOUS AND TECHNICAL AMENDMENTS RELATING TO PEER REVIEW ORGANIZATIONS.**—

(1) **CLARIFICATION OF PATIENT NOTIFICATION REQUIREMENTS FOR DENIAL OF PAYMENT BY PRO.**—

(A) **IN GENERAL.**—Section 1154(a)(3)(E) (42 U.S.C. 1320c-3(a)(3)(E)) is amended—

(i) by striking “(E)” and inserting “(E)(i)”;

(ii) by inserting after “items” the following: “provided by a physician that were”;

(iii) by striking “physician and hospital.” and inserting “physician.”; and

(iv) by adding at the end the following new clause:

“(ii) In the case of services or items provided by an entity or practitioner other than a physician, the Secretary may substitute the entity or practitioner which provided the services or items for the term ‘physician’ in the notice described in clause (i).”.

(B) **EFFECTIVE DATE.**—The amendments made by subparagraph (A) shall take effect as if included in the enactment of the Omnibus Budget Reconciliation ²² Act of 1989.

42 USC 1320c-3
note.

(2) **CLARIFICATION OF APPLICATION OF CRITERIA FOR DENIAL OF PAYMENT.**—

(A) **IN GENERAL.**—Section 1154(a)(2) (42 U.S.C. 1320c-3(a)(2)) is amended by striking the third sentence and inserting the following: “The organization shall identify cases for which payment should not be made by reason of paragraph (1)(B) only through the use of criteria developed pursuant to guidelines established by the Secretary.”.

(B) **EFFECTIVE DATE.**—The amendment made by subparagraph (A) shall take effect as if included in the enactment of the Consolidated Omnibus Budget Reconciliation Act of 1985.

42 USC 1320c-3
note.

SEC. 4206. MEDICARE PROVIDER AGREEMENTS ASSURING THE IMPLEMENTATION OF A PATIENT'S RIGHT TO PARTICIPATE IN AND DIRECT HEALTH CARE DECISIONS AFFECTING THE PATIENT.

(a) **IN GENERAL.**—Section 1866(a)(1) (42 U.S.C. 1395cc(a)(1)) is amended—

(1) in subsection (a)(1)—

(A) by striking “and” at the end of subparagraph (O),
(B) by striking the period at the end of subparagraph (P) and inserting “, and”, and

(C) by inserting after subparagraph (P) the following new subparagraph:

“(Q) in the case of hospitals, skilled nursing facilities, home health agencies, and hospice programs, to comply with the requirement of subsection (f) (relating to maintaining written policies and procedures respecting advance directives).”; and

(2) by inserting after subsection (e) the following new subsection:

“(f)(1) For purposes of subsection (a)(1)(Q) and sections 1819(c)(2)(E), 1833(r), 1876(c)(8), and 1891(a)(6), the requirement of this subsection is that a provider of services or prepaid or eligible organization (as the case may be) maintain written policies and procedures with respect to all adult individuals receiving medical care by or through the provider or organization—

“(A) to provide written information to each such individual concerning—

“(i) an individual's rights under State law (whether statutory or as recognized by the courts of the State) to make decisions concerning such medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives (as defined in paragraph (3)), and

“(ii) the written policies of the provider or organization respecting the implementation of such rights;

“(B) to document in the individual's medical record whether or not the individual has executed an advance directive;

“(C) not to condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;

“(D) to ensure compliance with requirements of State law (whether statutory or as recognized by the courts of the State)

²² So in original. Probably should be “Reconciliation”.

respecting advance directives at facilities of the provider or organization; and

“(E) to provide (individually or with others) for education for staff and the community on issues concerning advance directives.

Subparagraph (C) shall not be construed as requiring the provision of care which conflicts with an advance directive.

“(2) The written information described in paragraph (1)(A) shall be provided to an adult individual—

“(A) in the case of a hospital, at the time of the individual’s admission as an inpatient,

“(B) in the case of a skilled nursing facility, at the time of the individual’s admission as a resident,

“(C) in the case of a home health agency, in advance of the individual coming under the care of the agency,

“(D) in the case of a hospice program, at the time of initial receipt of hospice care by the individual from the program, and

“(E) in the case of an eligible organization (as defined in section 1876(b)) or an organization provided payments under section 1833(a)(1)(A), at the time of enrollment of the individual with the organization.

“(3) In this subsection, the term ‘advance directive’ means a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State) and relating to the provision of such care when the individual is incapacitated.”

(b) APPLICATION TO PREPAID ORGANIZATIONS.—

(1) ELIGIBLE ORGANIZATIONS.—Section 1876(c) of such Act (42 U.S.C. 1395mm(c)) is amended by adding at the end the following new paragraph:

“(8) A contract under this section shall provide that the eligible organization shall meet the requirement of section 1866(f) (relating to maintaining written policies and procedures respecting advance directives).”

(2) OTHER PREPAID ORGANIZATIONS.—Section 1833 of such Act (42 U.S.C. 1395l) is amended by adding at the end the following new subsection:

“(r) The Secretary may not provide for payment under subsection (a)(1)(A) with respect to an organization unless the organization provides assurances satisfactory to the Secretary that the organization meets the requirement of section 1866(f) (relating to maintaining written policies and procedures respecting advance directives).”

(c) EFFECT ON STATE LAW.—Nothing in subsections (a) and (b) shall be construed to prohibit the application of a State law which allows for an objection on the basis of conscience for any health care provider or any agent of such provider which, as a matter of conscience, cannot implement an advance directive.

(d) CONFORMING AMENDMENTS.—

(1) Section 1819(c)(1) of such Act (42 U.S.C. 1395i-3(c)(1)) is amended by adding at the end the following new subparagraph:

“(E) INFORMATION RESPECTING ADVANCE DIRECTIVES.—A skilled nursing facility must comply with the requirement of section 1866(f) (relating to maintaining written policies and procedures respecting advance directives).”

(2) Section 1891(a) of such Act (42 U.S.C. 1395bbb(a)) is amended by adding at the end the following:

“(6) The agency complies with the requirement of section 1866(f) (relating to maintaining written policies and procedures respecting advance directives).”.

(e) **EFFECTIVE DATES.**—

(1) The amendments made by subsections (a) and (d) shall apply with respect to services furnished on or after the first day of the first month beginning more than 1 year after the date of the enactment of this Act.

42 USC 1395i-3
note.

(2) The amendments made by subsection (b) shall apply to contracts under section 1876 of the Social Security Act and payments under section 1833(a)(1)(A) of such Act as of first day of the first month beginning more than 1 year after the date of the enactment of this Act.

42 USC 1395f
note.

SEC. 4027. MISCELLANEOUS AND TECHNICAL PROVISIONS RELATING TO PARTS A AND B.

(a) **HOSPITAL AND PHYSICIAN OBLIGATIONS WITH RESPECT TO EMERGENCY MEDICAL CONDITIONS.**—

(1) **PEER REVIEW.**—(A) Section 1867(d) (42 U.S.C. 1395dd(d)), as amended by section 4008(b)(3), is amended by adding at the end the following new paragraph:

“(3) **CONSULTATION WITH PEER REVIEW ORGANIZATIONS.**—In considering allegations of violations of the requirements of this section in imposing sanctions under paragraph (1), the Secretary shall request the appropriate utilization and quality control peer review organization (with a contract under part B of title XI) to assess whether the individual involved had an emergency medical condition which had not been stabilized, and provide a report on its findings. Except in the case in which a delay would jeopardize the health or safety of individuals, the Secretary shall request such a review before effecting a sanction under paragraph (1) and shall provide a period of at least 60 days for such review.”²³

(B) Section 1154(a) (42 U.S.C. 1320c-4(a)) is amended by adding at the end the following new paragraph:

42 USC 1320c-3
note.

“(16) The organization shall provide for a review and report to the Secretary when requested by the Secretary under section 1867(d)(3). The organization shall provide reasonable notice of the review to the physician and hospital involved. Within the time period permitted by the Secretary, the organization shall provide a reasonable opportunity for discussion with the physician and hospital involved, and an opportunity for the physician and hospital to submit additional information, before issuing its report to the Secretary under such section.”.

(C) The amendment made by subparagraph (A) shall take effect on the first day of the first month beginning more than 60 days after the date of the enactment of this Act. The amendment made by subparagraph (B) shall apply to contracts under part B of title XI of the Social Security Act as of the first day of the first month beginning more than 60 days after the date of the enactment of this Act.

42 USC 1320c-3
note.

(2) **CIVIL MONETARY PENALTIES.**—Section 1867(d)(2)(B) (42 U.S.C. 1395dd(d)(2)(B)) is amended by striking “knowingly” and inserting “negligently”.

(3) **EXCLUSION.**—Section 1867(d)(2)(B) (42 U.S.C. 1395dd(d)(2)(B)) is amended by striking “knowing and willful or negligent” and inserting “is gross and flagrant or is repeated”.

²³ So in original. Probably should be “review.”.

42 USC 1395dd
note.

(4) **EFFECTIVE DATE.**—The amendments made by this subsection shall apply to actions occurring on or after the first day of the sixth month beginning after the date of the enactment of this Act.

(b) **EXTENSIONS OF EXPIRING PROVISIONS.**—

42 USC 1395ww
note.

(1) **PROHIBITION ON COST SAVINGS POLICIES BEFORE BEGINNING OF FISCAL YEAR.**—Notwithstanding any other provision of law, the Secretary of Health and Human Services may not issue any proposed or final regulation, instruction, or other policy which is estimated by the Secretary to result in a net reduction in expenditures under title XVIII of the Social Security Act in a fiscal year (beginning with fiscal year 1991 and ending with fiscal year 1993, or, if later, the last fiscal year for which there is a maximum deficit amount specified under section 3(7) of the Congressional Budget and Impoundment Control Act of 1974) of more than \$50,000,000, except as follows:

(A) The Secretary may issue such a proposed regulation, instruction, or other policy with respect to the fiscal year before the May 15 preceding the beginning of the fiscal year.

(B) The Secretary may issue such a final regulation, instruction, or other policy with respect to the fiscal year on or after October 15 of the fiscal year.

(C) The Secretary may, at any time, issue such a proposed or final regulation, instruction, or other policy with respect to the fiscal year if required to implement specific provisions under statute.

42 USC 1395ww
note.

(2) **PROHIBITION OF PAYMENT CYCLE CHANGES.**—Notwithstanding any other provision of law, the Secretary of Health and Human Services is not authorized to issue, after the date of the enactment of this Act, any final regulation, instruction, or other policy change which is primarily intended to have the effect of slowing down or speeding up claims processing, or delaying payment of claims, under title XVIII of the Social Security Act.

42 USC 1395pp
note.

(3) **WAIVER OF LIABILITY FOR HOME HEALTH AGENCIES.**—Section 9305(g)(3) of the Omnibus Budget Reconciliation Act of 1986, as amended by section 426(d) of the Medicare Catastrophic Coverage Act of 1988, is amended by striking “November 1, 1990” and inserting “December 31, 1995”.

(4) **EXTENSION AND EXPANSION OF WAIVERS FOR SOCIAL HEALTH MAINTENANCE ORGANIZATIONS.**—

(A) **EXTENSION OF CURRENT WAIVERS.**—Section 4018(b) of the Omnibus Budget Reconciliation Act of 1987 is amended—

(i) in paragraph (1), by striking “September 30, 1992” and inserting “December 31, 1995”; and

(ii) in paragraph (4)—

(I) by striking “final” and inserting “second interim”, and

(II) by striking the period at the end and inserting the following: “, and shall submit a final report on the demonstration projects conducted under section 2355 of the Deficit Reduction Act of 1984 not later than March 31, 1996.”.

(B) **EXPANSION OF DEMONSTRATIONS.**—Section 2355 of the Deficit Reduction Act of 1984 is amended—

(i) in subsection (a), by adding at the end the following: “Not later than 12 months after the date of the enactment of the Omnibus Budget Reconciliation Act of 1990, the Secretary shall approve such applications or protocols for not more than 4 additional projects described in subsection (b).”;

(ii) by amending paragraph (1) of subsection (b) to read as follows:

“(1) to demonstrate—

“(A) the concept of a social health maintenance organization with the organizations as described in Project No. 18-P-9 7604/1-04 of the University Health Policy Consortium of Brandeis University, or

“(B) in the case of a project conducted as a result of the amendments made by section 12907(c)(4)(A) of the Omnibus Budget Reconciliation Act of 1990, the effectiveness and feasibility²⁴ of innovative approaches to refining targeting and financing methodologies and benefit design, including the effectiveness of feasibility of—

“(i) the benefits of expanded post-acute and community care case management through links between chronic care case management services and acute care providers;

“(ii) refining targeting or reimbursement methodologies;

“(iii) the establishment and operation of a rural services delivery system; or

“(iv) the effectiveness of second-generation sites in reducing the costs of the commencement and management of health care service delivery;”;

(iii) in subsection (b)—

(I) by inserting “and” at the end of paragraph (3),

(II) by striking the semicolon at the end of paragraph (4) and inserting a period, and

(III) by striking paragraphs (5), (6), and (7).²⁵

(iv) in subsection (c)—

(I) by striking “and” at the end of paragraph (1),

(II) by striking the period at the end of paragraph (2) and inserting “; and”, and

(III) by adding at the end the following new paragraph:

“(3) in the case of a project conducted as a result of the amendments made by section 12907(c)(4)(A) of the Omnibus Budget Reconciliation Act of 1990, any requirements of titles XVIII or XIX of the Social Security Act that, if imposed, would prohibit such project from being conducted.”; and

(v) by adding at the end the following new subsection:

“(e) There are authorized to be appropriated \$3,500,000 for the costs of technical assistance and evaluation related to projects conducted as a result of the amendments made by section 12907(c)(4)(A) of the Omnibus Budget Reconciliation Act of 1990.”.

(c) DEVELOPMENT OF PROSPECTIVE PAYMENT SYSTEM FOR HOME HEALTH SERVICES.—

(1) DEVELOPMENT OF PROPOSAL.—The Secretary of Health and Human Services shall develop a proposal to modify the current system under which payment is made for home health services under title XVIII of the Social Security Act or a proposal to

42 USC 1395x
note.

²⁴ So in original. Probably should be “feasibility”.

²⁵ So in original. Probably should be “(7);”.

replace such system with a system under which such payments would be made on the basis of prospectively determined rates. In developing any proposal under this paragraph to replace the current system with a prospective payment system, the Secretary shall—

(A) take into consideration the need to provide for appropriate limits on increases in expenditures under the medicare program;

(B) provide for adjustments to prospectively determined rates to account for changes in a provider's case mix, severity of illness of patients, volume of cases, and the development of new technologies and standards of medical practice;

(C) take into consideration the need to increase the payment otherwise made under such system in the case of services provided to patients whose length of treatment or costs of treatment greatly exceed the length or cost of treatment provided for under the applicable prospectively determined payment rate;

(D) take into consideration the need to adjust payments under the system to take into account factors such as differences in wages and wage-related costs among agencies located in various geographic areas and other factors the Secretary considers appropriate; and

(E) analyze the feasibility and appropriateness of establishing the episode of illness as the basic unit for making payments under the system.

(2) **REPORTS.**—(A) By not later than April 1, 1993, the Secretary of Health and Human Services shall submit the research findings upon which the proposal described in paragraph (1) shall be based to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives.

(B) By not later than September 1, 1993, the Secretary shall submit the proposal developed under paragraph (1) to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives.

(C) By not later than March 1, 1994, the Prospective Payment Assessment Commission shall submit an analysis of and comments on the proposal developed under paragraph (1) to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives.

(d) **HOME HEALTH WAGE INDEX.**—

(1) **IN GENERAL.**—Section 1861(v)(1)(L)(iii) (42 U.S.C. 1395x(v)(1)(L)(iii)) is amended to read as follows:

“(iii) Not later than July 1, 1991, and annually thereafter, the Secretary shall establish limits under this subparagraph for cost reporting periods beginning on or after such date by utilizing the area wage index applicable under section 1886(d)(3)(E) as of such date to hospitals located in the geographic area in which the home health agency is located (determined without regard to whether such hospitals have been reclassified to a new geographic area pursuant to section 1886(d)(8)(B), a decision of the Medicare Geographic Classification Review Board under section 1886(d)(10), or a decision of the Secretary).”.

(2) **APPLICATION ON BUDGET-NEUTRAL BASIS.**—In updating the wage index for establishing limits under section 1861(v)(1)(L)(iii)

of the Social Security Act, the Secretary shall ensure that aggregate payments to home health agencies under title XVIII of such Act will be no greater or lesser than such payments would have been without regard to such update.

(3) **TRANSITION PROVISION.**—Notwithstanding section 1861(v)(1)(L)(iii) of the Social Security Act, the Secretary of Health and Human Services shall, in determining the limits of reasonable costs under title XVIII of such Act with respect to services furnished by a home health agency, utilize a wage index equal to—

42 USC 1395x
note.

(A) for cost reporting periods beginning on or after July 1, 1991, and on or before June 30, 1992, a combined area wage index consisting of—

(i) 67 percent of the area wage index applicable under section 1861(v)(1)(L)(iii) of such Act to such home health agency, determined using the survey of the 1982 wages and wage-related costs of hospitals in the United States conducted under such section, and

(ii) 33 percent of the area wage index applicable under section 1886(d)(3)(E) of such Act to hospitals located in the geographic area in which the home health agency is located, determined using the survey of the 1988 wages and wage-related costs of hospitals in the United States conducted under such section; and

(B) for cost reporting periods beginning on or after July 1, 1992, and on or before June 30, 1993, a combined area wage index consisting of—

(i) 33 percent of the area wage index applicable under section 1861(v)(1)(L)(iii) of such Act to such home health agency, determined using the survey of the 1982 wages and wage-related costs of hospitals in the United States conducted under such section, and

(ii) 67 percent of the area wage index applicable under section 1886(d)(3)(E) of such Act to hospitals located in the geographic area in which the home health agency is located, determined using the survey of the 1988 wages and wage-related costs of hospitals in the United States conducted under such section.

(3) **EFFECTIVE DATE.**—The amendment made by paragraph (1) shall apply with respect to home health agency cost reporting periods beginning on or after July 1, 1991.

42 USC 1395x
note.

(e) **CLARIFICATION OF DEFINITIONS AND REPORTING REQUIREMENTS RELATING TO PHYSICIAN OWNERSHIP AND REFERRAL.**—

(1) **CLARIFYING DEFINITIONS.**—Section 1877(h) of the Social Security Act (42 U.S.C. 1395nn(h)) is amended—

(A) in paragraph (6)(A), by striking “in the case of” and all that follows through “the service,” and inserting “in the case of an item or service for which payment may be made under part B, the request by a physician for the item or service,”;

(B) in paragraph (6)(B), by striking “in the case of another clinical laboratory service,”, and

(C) by redesignating paragraph (6) as paragraph (7) and by inserting after paragraph (5) the following new paragraph:

“(6) INVESTOR.—The term ‘investor’ means, with respect to an entity, a person with a financial relationship specified in subsection (a)(2) with the entity.”.

(2) EXEMPTION FOR FINANCIAL RELATIONSHIPS WITH HOSPITAL UNRELATED TO THE PROVISION OF CLINICAL LABORATORY SERVICES.—Section 1877(b) is amended by redesignating paragraph (4) as paragraph (5) and by inserting after paragraph (3) the following new paragraph:

“(4) HOSPITAL FINANCIAL RELATIONSHIP UNRELATED TO THE PROVISION OF CLINICAL LABORATORY SERVICES.—In the case of a financial relationship with a hospital if the financial relationship does not relate to the provision of clinical laboratory services.”.

(3) REVISION OF REPORTING REQUIREMENTS.—Section 1877(f) (42 U.S.C. 1395nn(f)) is amended—

(A) by amending paragraph (2) to read as follows:

“(2) the names and unique physician identification numbers of all physicians with an ownership or investment interest (as described in subsection (a)(2)(A)) in the entity, or whose immediate relatives have such an ownership or investment.”;

(B) in the third sentence, by striking “1 year after the date of the enactment of this section” and inserting “October 1, 1991”; and

(C) by adding at the end the following new sentences: “The requirement of this subsection shall not apply to covered items and services provided outside the United States or to entities which the Secretary determines provides services for which payment may be made under this title very infrequently. The Secretary may waive the requirements of this subsection (and the requirements of chapter 35 of title 44, United States Code, with respect to information provided under this subsection) with respect to reporting by entities in a State (except for entities providing clinical laboratory services) so long as such reporting occurs in at least 10 States, and the Secretary may waive such requirements with respect to the providers in a State required to report so long as such requirements are not waived with respect to parenteral and enteral suppliers, end stage renal disease facilities, suppliers of ambulance services, hospitals, entities providing physical therapy services, and entities providing diagnostic imaging services of any type.”.

(4) DATE OF ISSUANCE OF REPORTS AND REGULATIONS.—(A) Section 6204 of the Omnibus Budget Reconciliation Act of 1989 is amended by striking subsection (f) and inserting the following:

“(f) STATISTICAL SUMMARY OF COMPARATIVE UTILIZATION.—Not later than June 30, 1992, the Secretary of Health and Human Services shall submit to Congress a statistical profile comparing utilization of items and services by medicare beneficiaries served by entities in which the referring physician has a direct or indirect financial interest and by medicare beneficiaries served by other entities, for the States and entities specified in section 1877(f) of the Social Security Act (other than entities providing clinical laboratory services).”.

(B) Section 6204(d) of the Omnibus Budget Reconciliation Act of 1989 is amended by striking “October 1, 1990” and inserting “October 1, 1991”

42 USC 1395nn
note.

42 USC 1395nn
note.

(5) **EFFECTIVE DATE.**—The amendments made by this subsection shall be effective as if included in the enactment of section 6204 of the Omnibus Budget Reconciliation Act of 1989.

42 USC 1395nn
note.

(f) **CASE MANAGEMENT DEMONSTRATION PROJECT.**—

42 USC 1395b-1
note.

(1) **IN GENERAL.**—Notwithstanding any other provision of law, the Secretary of Health and Human Services shall resume the 3 case management demonstration projects described in paragraph (2) and approved under section 425 of the Medicare Catastrophic Coverage Act of 1988 (in this subsection referred to as “MCCA”).

(2) **PROJECT DESCRIPTIONS.**—The demonstration projects referred to in paragraph (1) are—

(A) the project proposed to be conducted by Providence Hospital for case management of the elderly at risk for acute hospitalization as described in Project No. 18-P-99379/5-01;

(B) the project proposed to be conducted by the Iowa Foundation for Medical Care to study patients with chronic congestive conditions to reduce repeated hospitalizations of such patients as described in Project No. P-99399/4-01; and

(C) the project proposed to be conducted by Key Care Health Resources, Inc., to examine the effects of case management on 2,500 high cost medicare beneficiaries as described in Project No. 18-P-99396/5.

(3) **TERMS AND CONDITIONS.**—Except as provided in paragraph (4), the demonstration projects resumed pursuant to paragraph (1) shall be subject to the same terms and conditions established under section 425 of MCCA. In determining the 2-year duration period of a project resumed pursuant to paragraph (1), the Secretary may not take into account any period of time for which the project was in effect under section 425 of MCCA.

(4) **AUTHORIZATION OF APPROPRIATIONS.**—Notwithstanding section 425(g) of MCCA, there are authorized to be appropriated for administrative costs in carrying out the demonstration projects resumed pursuant to paragraph (1) \$2,000,000 in each of fiscal years 1991 and 1992.

(g) **PROHIBITION OF USER FEES FOR SURVEY AND CERTIFICATION.**—Section 1864 (42 U.S.C. 1395aa) is amended by adding at the end the following new subsection:

“(e) Notwithstanding any other provision of law, the Secretary may not impose, or require a State to impose, any fee on any facility or entity subject to a determination under subsection (a), or any renal dialysis facility subject to the requirements of section 1881(b)(1), for any such determination or any survey relating to determining the compliance of such facility or entity with any requirement of this title.”.

(h) **DELEGATION OF AUTHORITY TO INSPECTOR GENERAL.**—Section 1128A(j) (42 U.S.C. 1320a-7a(j)) is amended—

(i) by striking “(j)” and inserting “(j)(1)”; and

(ii) by adding at the end the following new paragraph:

“(2) The Secretary may delegate authority granted under this section and under section 1128 to the Inspector General of the Department of Health and Human Services.”.

(i) **MODIFICATION OF HOME HEALTH AGENCY DEFICIENCY STANDARDS.**—

(1) **IN GENERAL.**—Effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1987, section

1891(a)(3)(D)(iii) of the Social Security Act (42 U.S.C. 1395bbb(a)(3)(D)(iii)) is amended by striking “which has been determined” and all that follows and inserting the following: “which, within the previous 2 years—

“(I) has been determined to be out of compliance with subparagraph (A), (B), or (C);

“(II) has been subject to an extended (or partial extended) survey under subsection (c)(2)(D);

“(III) has been assessed a civil money penalty described in subsection (f)(2)(A)(i) of not less than \$5,000; or

“(IV) has been subject to the remedies described in subsection (e)(1) or in clauses (ii) or (iii) of subsection (f)(2)(A).”.

42 USC 1395bbb
note.

(2) **EFFECTIVE DATE.**—The amendments made by paragraph (1) shall take effect as if included in the enactment of the Omnibus Budget Reconciliation Act of 1987, except that the Secretary may not permit approval of a training and competency evaluation program or a competency evaluation program offered by or in a home health agency which, pursuant to any Federal or State law within the 2-year period beginning on October 1, 1988—

(i) had its participation terminated under title XVIII of the Social Security Act;

(ii) was assessed a civil money penalty not less than \$5,000 for deficiencies in applicable quality standards for home health agencies;

(iii) was subject to suspension by the Secretary of all or part of the payments to which it would otherwise be entitled under such title.²⁶

(iv) operated under a temporary management appointed to oversee the operation of the agency and to ensure the health and safety of the agency's patients; or

(v) pursuant to State action, was closed or had its residents transferred.

42 USC 1395hh
note.

(j) **USE OF INTERIM FINAL REGULATIONS.**—The Secretary of Health and Human Services shall issue such regulations (on an interim or other basis) as may be necessary to implement this title and the amendments made by this title.

(k) **MISCELLANEOUS TECHNICAL CORRECTIONS.**—

(1) The third sentence of subsections (a) and (b)(1) of section 1882 of the Social Security Act (42 U.S.C. 1395ss), as amended by section 203(a)(1)(A) of the Medicare Catastrophic Coverage Repeal Act, is amended by striking “(k)(4).”.

42 USC 1395nn.

(2) Section 1877(g)(5) of the Social Security Act, as added by section 6204(a) of OBRA-1989, is amended by adding at the end the following new sentence: “The provisions of section 1128A (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).”.

42 USC 1395dd.

(3) Subsection (i) of section 1867 of the Social Security Act, as added by section 6211(f) of the Omnibus Budget Reconciliation Act of 1989, is amended to read as follows:

“(i) **WHISTLEBLOWER PROTECTIONS.**—A participating hospital may not penalize or take adverse action against a qualified medical person described in subsection (c)(1)(A)(iii) or a physician because the

²⁶ So in original. Probably should be “.”.

person or physician refuses to authorize the transfer of an individual with an emergency medical condition that has not been stabilized or against any hospital employee because the employee reports a violation of a requirement of this section.”.

(4) Section 6213(d) of the Omnibus Budget Reconciliation Act of 1989 is amended by striking “take effect” and inserting “apply to services furnished on or after”.

42 USC 1395x
note.

(5) Section 6217(a) of the Omnibus Budget Reconciliation Act of 1989 is amended in the matter preceding paragraph (1) by inserting after “payments” the following: “out of the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund (in such proportions as the Secretary determines to be appropriate in a year)”.

42 USC 1395ww
note.

(6) Section 1139(d) of the Social Security Act, as amended by section 6221 of Omnibus Budget Reconciliation Act of 1989, is amended by striking “interim report” and all that follows through “setting forth” and inserting the following: “interim report no later than March 31, 1990, and a final report no later than March 31, 1991, setting forth”.

42 USC 1320b-9.

PART 4—PROVISIONS RELATING TO MEDICARE

PART B PREMIUM AND DEDUCTIBLE

SEC. 4301. PART B PREMIUM.

Section 1839(e)(1) (42 U.S.C. 1395r(e)(1)) is amended—

(1) by inserting “(A)” after “(e)(1)”, and

(2) by adding at the end the following new subparagraph:

“(B) Notwithstanding the provisions of subsection (a), the monthly premium for each individual enrolled under this part for each month in—

“(i) 1991 shall be \$29.90,

“(ii) 1992 shall be \$31.80,

“(iii) 1993 shall be \$36.60,

“(iv) 1994 shall be \$41.10, and

“(v) 1995 shall be \$46.10.”

SEC. 4302. PART B DEDUCTIBLE.

Section 1833(b) (42 U.S.C. 1395l) is amended by inserting after “\$75” the following: “for calendar years before 1991 and \$100 for 1991 and subsequent years”

PART 5—MEDICARE SUPPLEMENTAL INSURANCE POLICIES

SEC. 4351. SIMPLIFICATION OF MEDICARE SUPPLEMENTAL POLICIES.

(a) IN GENERAL.—Section 1882 (42 U.S.C. 1395ss) is amended—

(1) in subsection (b)(1)(B), by striking “through (4)” and inserting “through (5)”;

(2) in subsection (c)—

(A) by striking “and” at the end of paragraph (3),

(B) by striking the period at the end of paragraph (4) and inserting “; and”, and

(C) by inserting after paragraph (4) the following new paragraph:

“(5) meets the applicable requirements of subsections (o) through (t).”; and

(3) by adding at the end the following new subsections:

“(o) The requirements of this subsection are as follows:

“(1) Each medicare supplemental policy shall provide for coverage of a group of benefits consistent with subsection (p).

“(2) If the medicare supplemental policy provides for coverage of a group of benefits other than the core group of basic benefits described in subsection (p)(2)(B), the issuer of the policy must make available to the individual a medicare supplemental policy with only such core group of basic benefits.

“(3) The issuer of the policy has provided, before the sale of the policy, an outline of coverage that uses uniform language and format (including layout and print size) that facilitates comparison among medicare supplemental policies and comparison with medicare benefits.

“(p)(1)(A) If, within 9 months after the date of the enactment of this subsection, the National Association of Insurance Commissioners (in this subsection referred to as the ‘Association’) promulgates—

“(i) limitations on the groups or packages of benefits that may be offered under a medicare supplemental policy consistent with paragraphs (2) and (3) of this subsection,

“(ii) uniform language and definitions to be used with respect to such benefits,

“(iii) uniform format to be used in the policy with respect to such benefits, and

“(iv) other standards to meet the additional requirements imposed by the amendments made by the Omnibus Budget Reconciliation Act of 1990,

(such limitations, language, definitions, format, and standards referred to collectively in this subsection as ‘NAIC standards’), subsection (g)(2)(A) shall be applied in each State, effective for policies issued to policyholders on and after the date specified in subparagraph (C), as if the reference to the Model Regulation adopted on June 6, 1979, included a reference to the NAIC standards.

“(B) If the Association does not promulgate NAIC standards within the 9-month period specified in subparagraph (A), the Secretary shall promulgate, not later than 9 months after the end of such period, limitations, language, definitions, format, and standards described in clauses (i) through (iv) of such subparagraph (in this subsection referred to collectively as ‘Federal standards’) and subsection (g)(2)(A) shall be applied in each State, effective for policies issued to policyholders on and after the date specified in subparagraph (C), as if the reference to the Model Regulation adopted on June 6, 1979, included a reference to the Federal standards.

“(C)(i) Subject to clause (ii), the date specified in this subparagraph for a State is the date the State adopts the NAIC standards or the Federal standards or 1 year after the date the Association or the Secretary first adopts such standards, whichever is earlier.

“(ii) In the case of a State which the Secretary identifies, in consultation with the Association, as—

“(I) requiring State legislation (other than legislation appropriating funds) in order for medicare supplemental policies to meet the NAIC or Federal standards, but

“(II) having a legislature which is not scheduled to meet in 1992 in a legislative session in which such legislation may be considered,

the date specified in this subparagraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 1992. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

“(D) In promulgating standards under this paragraph, the Association or Secretary shall consult with a working group composed of representatives of issuers of medicare supplemental policies, consumer groups, medicare beneficiaries, and other qualified individuals. Such representatives shall be selected in a manner so as to assure balanced representation among the interested groups.

“(E) If benefits (including deductibles and coinsurance) under this title are changed and the Secretary determines, in consultation with the Association, that changes in the NAIC or Federal standards are needed to reflect such changes, the preceding provisions of this paragraph shall apply to the modification of standards previously established in the same manner as they applied to the original establishment of such standards.

“(2) The benefits under the NAIC or Federal standards shall provide—

“(A) for such groups or packages of benefits as may be appropriate taking into account the considerations specified in paragraph (3) and the requirements of the succeeding subparagraphs;

“(B) for identification of a core group of basic benefits common to all policies, and

“(C) that, subject to paragraph (5)(B), the total number of different benefit packages (counting the core group of basic benefits described in subparagraph (B) and each other combination of benefits that may be offered as a separate benefit package) that may be established in all the States and by all issuers shall not exceed 10.

“(3) The benefits under paragraph (2) shall, to the extent possible—

“(A) provide for benefits that offer consumers the ability to purchase the benefits that are available in the market as of the date of the enactment of this subsection; and

“(B) balance the objectives of (i) simplifying the market to facilitate comparisons among policies, (ii) avoiding adverse selection, (iii) providing consumer choice, (iv) providing market stability, and (v) promoting competition.

“(4)(A)(i) Except as provided in subparagraph (B), no State with a regulatory program approved under subsection (b)(1) may provide for or permit the grouping of benefits (or language or format with respect to such benefits) under a medicare supplemental policy unless such grouping meets the applicable standards.

“(ii) Except as provided in subparagraph (B), the Secretary may not provide for or permit the grouping of benefits (or language or format with respect to such benefits) under a medicare supplemental policy seeking approval by the Secretary unless such grouping meets the applicable standards.

“(B) With the approval of the State (in the case of a policy issued in a State with an approved regulatory program) or the Secretary (in the case of any other policy), the issuer of a medicare supplemental policy may offer new or innovative benefits in addition to the benefits provided in a policy that otherwise complies with the

applicable standards. Any such new or innovative benefits may include benefits that are not otherwise available and are cost-effective and shall be offered in a manner which is consistent with the goal of simplification of medicare supplemental policies.

“(5)(A) Except as provided in subparagraph (B), this subsection shall not be construed as preventing a State from restricting the groups of benefits that may be offered in medicare supplemental policies in the State.

“(B) A State with a regulatory program approved under subsection (b)(1) may not restrict under subparagraph (A) the offering of a medicare supplemental policy consisting only of the core group of benefits described in paragraph (2)(B).

“(6) The Secretary may waive the application of standards in regard to the limitation of benefits described in paragraph (4) in those States that on the date of enactment of this subsection had in place an alternative simplification program.

“(7) This subsection shall not be construed as preventing an issuer of a medicare supplemental policy who otherwise meets the requirements of this section from providing, through an arrangement with a vendor, for discounts from that vendor to policyholder or certificateholders for the purchase of items or services not covered under its medicare supplemental policies.

“(8) Any person who sells or issues a medicare supplemental policy, after the effective date of the NAIC or Federal standards with respect to the policy, in violation of the previous requirements of this subsection is subject to a civil money penalty of not to exceed \$25,000 (or \$15,000 in the case of a seller who is not an issuer of a policy) for each such violation. The provisions of section 1128A (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

“(9)(A) Anyone who sells a medicare supplemental policy to an individual shall make available for sale to the individual a medicare supplemental policy with only the core group of basic benefits (described in paragraph (2)(B)).

“(B) Anyone who sells a medicare supplemental policy to an individual shall provide the individual, before the sale of the policy, an outline of coverage which describes the benefits under the policy. Such outline shall be on a standard form approved by the State regulatory program or the Secretary (as the case may be) consistent with the NAIC or Federal standards under this subsection.

“(C) Whoever sells a medicare supplemental policy in violation of this paragraph is subject to a civil money penalty of not to exceed \$25,000 (or \$15,000 in the case of a seller who is not the issuer of the policy) for each such violation. The provisions of section 1128A (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

“(10) No penalty may be imposed under paragraph (8) or (9) in the case of a seller who is not the issuer of a policy until the Secretary has published a list of the groups of benefit packages that may be sold or issued consistent with this subsection.”.

SEC. 4352. GUARANTEED RENEWABILITY.

Section 1882 is amended by adding at the end the following new subsection: 42 USC 1395ss.

“(q) The requirements of this subsection are as follows:

“(1) Each medicare supplemental policy shall be guaranteed renewable and—

“(A) the issuer may not cancel or nonrenew the policy solely on the ground of health status of the individual; and

“(B) the issuer shall not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation.

“(2) If the medicare supplemental policy is terminated by the group policyholder and is not replaced as provided under paragraph (2), the issuer shall offer certificateholders an individual medicare supplemental policy which (at the option of the certificateholder)—

“(A) provides for continuation of the benefits contained in the group policy, or

“(B) provides for such benefits as otherwise meets the requirements of this section.

“(3) If an individual is a certificateholder in a group medicare supplemental policy and the individual terminates membership in the group, the issuer shall—

“(A) offer the certificateholder the conversion opportunity described in paragraph (2), or

“(B) at the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy.

“(4) If a group medicare supplemental policy is replaced by another group medicare supplemental policy purchased by the same policyholder, the succeeding issuer shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new group policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.”.

SEC. 4353. ENFORCEMENT OF STANDARDS.

(a) **REQUIRING CONFORMITY WITH STANDARDS.**—Section 1882 is amended—

(1) in the heading, by striking “VOLUNTARY”; and

(2) in subsection (a)—

(A) by inserting “(1)” after “(a)”,

(B) by adding at the end the following new paragraph:

“(2) No medicare supplemental policy may be issued in a State on or after the date specified in subsection (p)(1)(C) unless—

“(A) the State’s regulatory program under subsection (b)(1) provides for the application and enforcement of the standards and requirements set forth in such subsection (including the NAIC standards or the Federal standards (as the case may be)) by the date specified in subsection (p)(1)(C); or

“(B) if the State’s program does not provide for the application and enforcement of such standards and requirements, the policy has been certified by the Secretary under paragraph (1) as meeting the standards and requirements set forth in subsection (c) (including such applicable standards) by such date.

Any person who issues a medicare supplemental policy, after the effective date of the NAIC or Federal standards with respect to the

policy, in violation of this paragraph is subject to a civil money penalty of not to exceed \$25,000 for each such violation. The provisions of section 1128A (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a)."

42 USC 1395ss.

(b) PERIODIC REVIEW OF STATE REGULATORY PROGRAMS.—Section 1882(b) is amended—

(1) in paragraph (1), by striking "Supplemental Health Insurance Panel (established under paragraph (2))" and inserting "the Secretary",

(2) in paragraph (1), by striking "the Panel" and inserting "the Secretary",

(3) in subparagraphs (A) and (D) of paragraph (1), by inserting "and enforcement" after "application", and

(4) by amending paragraph (2) to read as follows:

"(2) The Secretary periodically shall review State regulatory programs to determine if they continue to meet the standards and requirements specified in paragraph (1). If the Secretary finds that a State regulatory program no longer meets the standards and requirements, before making a final determination, the Secretary shall provide the State an opportunity to adopt such a plan of correction as would permit the State regulatory program to continue to meet such standards and requirements. If the Secretary makes a final determination that the State regulatory program, after such an opportunity, fails to meet such standards and requirements, the program shall no longer be considered to have in operation a program meeting such standards and requirements."

(c) ENFORCEMENT BY STATES.—Section 1882(b)(1) (42 U.S.C. 1395ss(b)(1)) is amended—

(1) by striking "and" at the end of subparagraph (D);

(2) by inserting "and" at the end of subparagraph (E);

(3) by inserting after subparagraph (E) the following:

"(F) reports to the Secretary on the implementation and enforcement of standards and requirements of this paragraph at intervals established by the Secretary,"; and

(5) by adding at the end the following new sentence: "The report required under subsection (F) shall include information on loss ratios of policies sold in the State, frequency and types of instances in which policies approved by the State fail to meet the standards of this paragraph, actions taken by the State to bring such policies into compliance, and information regarding State programs implementing consumer protection provisions, and such further information as the Secretary in consultation with the National Association of Insurance Commissioners, may specify."

(d) REQUIRING APPROVAL OF STATE FOR SALE IN THE STATE.—

(1) IN GENERAL.—Section 1882(d)(4)(B) (42 U.S.C. 1395ss(d)(4)(B)) is amended by striking the second sentence.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to policies mailed, or caused to be mailed, on and after July 1, 1991.

42 USC 1395ss
note.

SEC. 4354. PREVENTING DUPLICATION.

(a) IN GENERAL.—Subsection (d)(3) of section 1882 (42 U.S.C. 1395ss) is amended—

(1) in subparagraph (A)—

(A) by striking “Whoever knowingly sells” and inserting “It is unlawful for a person to sell or issue”

(B) by striking “substantially”,

(C) by striking “, shall be fined” and inserting “. Whoever violates the previous sentence shall be fined”,

(D) in subparagraph (A), by inserting “or title XIX” after “other than this title”,

(E) in subparagraph (A), by striking “\$5,000” and inserting “\$25,000 (or \$15,000 in the case of a person other than the issuer of the policy)”, and

(F) by adding at the end the following: “A seller (who is not the issuer of a health insurance policy) shall not be considered to violate the previous sentence if the policy is sold in compliance with subparagraph (B) and the statement under such subparagraph indicates on its face that the sale of the policy will not duplicate health benefits to which the individual is otherwise entitled. This subsection shall not apply to such a seller until such date as the Secretary publishes a list of the standardized benefit packages that may be offered consistent with subsection (p).”;

(2) by amending subparagraph (B) to read as follows:

“(B)(i) It is unlawful for a person to issue or sell a medicare supplemental policy to an individual entitled to benefits under part A or enrolled under part B, whether directly, through the mail, or otherwise, unless—

“(I) the person obtains from the individual, as part of the application for the issuance or purchase and on a form described in clause (ii), a written statement signed by the individual stating, to the best of the individual’s knowledge, what health insurance policies the individual has, from what source, and whether the individual is entitled to any medical assistance under title XIX, whether as a qualified medicare beneficiary or otherwise, and

“(II) the written statement is accompanied by a written acknowledgment, signed by the seller of the policy, of the request for and receipt of such statement.

“(ii) The statement required by clause (i) shall be made on a form that—

“(I) states in substance that a medicare-eligible individual does not need more than one medicare supplemental policy,

“(II) states in substance that individuals 65 years of age or older may be eligible for benefits under the State medicaid program under title XIX and that such individuals who are entitled to benefits under that program usually do not need a medicare supplemental policy and that benefits and premiums under any such policy shall be suspended upon request of the policyholder during the period (of not longer than 24 months) of entitlement to benefits under such title and may be reinstituted upon loss of such entitlement, and

“(III) states that counseling services may be available in the State to provide advice concerning the purchase of medicare supplemental policies and enrollment under the medicaid program and may provide the telephone number for such services.

“(iii)(I) Except as provided in subclauses (II) and (III), if the statement required by clause (i) is not obtained or indicates that the individual has another medicare supplemental policy or indicates that the individual is entitled to any medical assistance under title

XIX, the sale of such a policy shall be considered to be a violation of subparagraph (A).

“(II) Subclause (I) shall not apply in the case of an individual who has another policy, if the individual indicates in writing, as part of the application for purchase, that the policy being purchased replaces such other policy and indicates an intent to terminate the policy being replaced when the new policy becomes effective and the issuer or seller certifies in writing that such policy will not, to the best of the issuer or seller’s knowledge, duplicate coverage (taking into account any such replacement).

“(III) Subclause (I) also shall not apply if a State medicaid plan under title XIX pays the premiums for the policy, or pays less than an individual’s (who is described in section 1905(p)(1)) full liability for medicare cost sharing as defined in section 1905(p)(3)(A).

“(iv) Whoever issues or sells a medicare supplemental policy in violation of this subparagraph shall be fined under title 18, United States Code, or imprisoned not more than 5 years, or both, and, in addition to or in lieu of such a criminal penalty, is subject to a civil money penalty of not to exceed \$25,000 (or \$15,000 in the case of a seller who is not the issuer of a policy) for each such violation.”.

(b) **SUSPENSION OF POLICY DURING MEDICAID ENTITLEMENT.**—Section 1882(q), as added by section 4352, is amended by adding at the end the following new paragraph:

“(5)(A) Each medicare supplemental policy shall provide that benefits and premiums under the policy shall be suspended at the request of the policyholder for the period (not to exceed 24 months) in which the policyholder has applied for and is determined to be entitled to medical assistance under title XIX of the Social Security Act, but only if the policyholder notifies the issuer of such policy within 90 days after the date the individual becomes entitled to such assistance. If such suspension occurs and if the policyholder or certificate holder loses entitlement to such medical assistance, such policy shall be automatically reinstituted (effective as of the date of termination of such entitlement) under terms described in subsection (n)(6)(A)(ii) as of the termination of such entitlement if the policyholder provides notice of loss of such entitlement within 90 days after the date of such loss.

“(B) Nothing in this section shall be construed as affecting the authority of a State, under title XIX of the Social Security Act, to purchase a medicare supplemental policy for an individual otherwise entitled to assistance under such title.

“(C) Any person who issues a medicare supplemental policy and fails to comply with the requirements of this paragraph is subject to a civil money penalty of not to exceed \$25,000 for each such violation. The provisions of section 1128A (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).”.

(c) **EFFECTIVE DATE.**—The amendments made by this section shall apply to policies issued or sold more than 1 year after the date of the enactment of this Act.

SEC. 4355. LOSS RATIOS AND REFUND OF PREMIUMS.

(a) **IN GENERAL.**—Section 1882 (42 U.S.C. 1395ss) is further amended—

(1) in subsection (c), by amending paragraph (2) to read as follows:

“(2) meets the requirements of subsection (r);”;

(2) by striking the sentence following subsection (c)(4); and

(3) by adding at the end the following new subsection:

“(r)(1) A medicare supplemental policy may not be issued or sold in any State unless—

“(A) the policy can be expected (as estimated for the entire period for which rates are computed to provide coverage, on the basis of incurred claims experience and earned premiums for such periods and in accordance with a uniform methodology, including uniform reporting standards, developed by the National Association of Insurance Commissioners²⁷, to return to policyholders in the form of aggregate benefits provided under the policy, at least 75 percent of the aggregate amount of premiums collected in the case of group policies and at least 65 percent in the case of individual policies; and

“(B) the issuer of the policy provides for the issuance of a proportional refund, or a credit against future premiums of a proportional amount, based on the premium paid and in accordance with paragraph (2), of the amount of premiums received necessary to assure that the ratio of aggregate benefits provided to the aggregate premiums collected (net of such refunds or credits) complies with the expectation required under subparagraph (A).

For purposes of applying subparagraph (A) only, policies issued as a result of solicitations of individuals through the mails or by mass media advertising (including both print and broadcast advertising) shall be deemed to be individual policies.

“(2)(A) Paragraph (1)(B) shall be applied with respect to each type of policy by policy number. Paragraph (1)(B) shall not apply to a policy with respect to the first 2 years in which it is in effect. The Comptroller General, in consultation with the National Association of Insurance Commissioners, shall submit to Congress a report containing recommendations on adjustments in the percentages under paragraph (1)(A) that may be appropriate in order to apply paragraph (1)(B) to the first 2 years in which policies are effective.

“(B) A refund or credit required under paragraph (1)(B) shall be made to each policyholder insured under the applicable policy as of the last day of the year involved.

“(C) Such a refund or credit shall include interest from the end of the policy year involved until the date of the refund or credit at a rate as specified by the Secretary for this purpose from time to time which is not less than the average rate of interest for 13-week Treasury notes.

“(D) For purposes of this paragraph and paragraph (1)(B), refunds or credits against premiums due shall be made, with respect to a policy year, not later than the third quarter of the succeeding policy year.

“(3) The provisions of this subsection do not preempt a State from requiring a higher percentage than that specified in paragraph (1)(A).

“(4) The Secretary shall submit in February of each year (beginning with 1993) a report to the Committees on Energy and Commerce and Ways and Means of the House of Representatives and the Committee on Finance of the Senate on loss-ratios under medicare supplemental policies and the use of sanctions, such as a required

²⁷ So in original. Probably should be “Commissioners”).

rebate or credit or the disallowance²⁸ of premium increases, for policies that fail to meet the requirements of this subsection (relating to loss-ratios). Such report shall include a list of the policies that failed to comply with such loss-ratio requirements or other requirements of this section.

“(5)(A) The Comptroller General shall periodically, not less often than once every 3 years, perform audits with respect to the compliance of medicare supplemental policies with the loss ratio requirements of this subsection and shall report the results of such audits to the State involved and to the Secretary.

“(B) The Secretary may independently perform such compliance audits.

“(6)(A) A person who issues a policy in violation of the loss ratio requirements of this subsection is subject to a civil money penalty of not to exceed \$25,000 for each such violation. The provisions of section 1128A (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

“(B) Each issuer of a policy subject to the requirements of paragraph (1)(B) shall be liable to policyholders for credits required under such paragraph.”.

(b) ASSURING ACCESS TO LOSS RATIO INFORMATION.—Section 1882(b)(1)(C) (42 U.S.C. 1395ss(b)(1)(C)) is amended by striking the semicolon at the end and inserting a comma and the following:

“and that a copy of each such policy, the most recent premium for each such policy, and a listing of the ratio of benefits provided to premiums collected for the most recent 3-year period for each such policy issued or sold in the State is maintained and made available to interested persons;”.

(c) IMPLEMENTATION OF PROCESS TO APPROVE PREMIUM INCREASES.—Section 1882(b)(1) (42 U.S.C. 1395ss(b)(1)) is further amended—

(1) by striking “and” at the end of subparagraph (E);

(2) by adding “and” at the end of subparagraph (F);

(3) by adding at the end thereof the following new subparagraph:

“(G) provides for a process for approving or disapproving proposed premium increases with respect to such policies, and establishes a policy for the holding of public hearings prior to approval of a premium increase.”.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to policies sold or issued more than 1 year after the date of the enactment of this Act.

SEC. 4356. CLARIFICATION OF TREATMENT OF PLANS OFFERED BY HEALTH MAINTENANCE ORGANIZATIONS.

(a) IN GENERAL.—The first sentence of section 1882(g)(1) is amended by inserting before the period at the end the following: “and does not include a policy or plan of a health maintenance organization or other direct service organization which offers benefits under this title, including such services under a contract under section 1876 or an agreement under section 1833”.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date of the enactment of this Act.

42 USC 1395ss
note.

42 USC 1395ss
note.

²⁸ So in original. Probably should be “disallowance”.

SEC. 4357. PRE-EXISTING CONDITION LIMITATIONS AND LIMITATION ON MEDICAL UNDERWRITING.

(a) **IN GENERAL.**—Section 1882 is amended—

(1) in subsection (c), in the matter before paragraph (1), by inserting “or the requirement described in subsection (s)” after “paragraph (3)”, and

(2) by adding at the end the following new subsection:

“(s)(1) If a medicare supplemental policy replaces another medicare supplemental policy, the issuer of the replacing policy shall waive any time periods applicable to preexisting conditions, waiting period, elimination periods and probationary periods in the new medicare supplemental policy for similar benefits to the extent such time was spent under the original policy.

“(2)(A) The issuer of a medicare supplemental policy may not deny or condition the issuance or effectiveness of a medicare supplemental policy, or discriminate in the pricing of the policy, because of health status, claims experience, receipt of health care, or medical condition for which an application is submitted during the 6 month period beginning with the first month in which the individual (who is 65 years of age or older) first is enrolled for benefits under part B.

“(B) Subject to subparagraph (C), subparagraph (A) shall not be construed as preventing the exclusion of benefits under a policy, during its first 6 months, based on a pre-existing condition for which the policyholder received treatment or was otherwise diagnosed during the 6 months before it became effective.

“(C) If a medicare supplemental policy or certificate replaces another such policy or certificate which has been in effect for 6 months or longer, the replacing policy may not provide any time period applicable to pre-existing conditions, waiting periods, elimination periods, and probationary periods in the new policy or certificate for similar benefits.

“(3) Any issuer of a medicare supplemental policy that fails to meet the requirements of paragraphs (1) and (2) is subject to a civil money penalty of not to exceed \$5,000 for each such failure. The provisions of section 1128A (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).”.

(b) **EFFECTIVE DATE.**—The amendments made by subsection (a) shall take effect 1 year after the date of the enactment of this Act.

42 USC 1395ss
note.

SEC. 4358. MEDICARE SELECT POLICIES.

(a) **IN GENERAL.**—Section 1882 (42 U.S.C. 1395ss) is further amended by adding at the end the following:

“(t)(1) If a policy meets the NAIC Model Standards and otherwise complies with the requirements of this section except that benefits under the policy are restricted to items and services furnished by certain entities (or reduced benefits are provided when items or services are furnished by other entities), the policy shall nevertheless be treated as meeting those standards if—

“(A) full benefits are provided for items and services furnished through a network of entities which have entered into contracts with the issuer of the policy;

“(B) full benefits are provided for items and services furnished by other entities if the services are medically necessary and immediately required because of an unforeseen illness, injury,

or condition and it is not reasonable given the circumstances to obtain the services through the network;

“(C) the network offers sufficient access;

“(D) the issuer of the policy has arrangements for an ongoing quality assurance program for items and services furnished through the network;

“(E)(i) the issuer of the policy provides to each enrollee at the time of enrollment an explanation of (I) the restrictions on payment under the policy for services furnished other than by or through the network, (II) out of area coverage under the policy, (III) the policy’s coverage of emergency services and urgently needed care, and (IV) the availability of a policy through the entity that meets the NAIC standards without reference to this subsection and the premium charged for such policy, and

“(ii) each enrollee prior to enrollment acknowledges receipt of the explanation provided under clause (i); and

“(F) the issuer of the policy makes available to individuals, in addition to the policy described in this subsection, any policy (otherwise offered by the issuer to individuals in the State) that meets the NAIC standards and other requirements of this section without reference to this subsection.

“(2) If the Secretary determines that an issuer of a policy approved under paragraph (1)—

“(A) fails substantially to provide medically necessary items and services to enrollees seeking such items and services through the issuer’s network, if the failure has adversely affected (or has substantial likelihood of adversely affecting) the individual,

“(B) imposes premiums on enrollees in excess of the premiums approved by the State,

“(C) acts to expel an enrollee for reasons other than nonpayment of premiums, or

“(D) does not provide the explanation required under paragraph (1)(E)(i) or does not obtain the acknowledgment required under paragraph (1)(E)(ii),

is subject to a civil money penalty in an amount not to exceed \$25,000 for each such violation. The provisions of section 1128A (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

“(3) The Secretary may enter into a contract with an entity whose policy has been certified under paragraph (1) or has been approved by a State under subsection (b)(1)(H) to determine whether items and services (furnished to individuals entitled to benefits under this title and under that policy) are not allowable under section 1862(a)(1). Payments to the entity shall be in such amounts as the Secretary may determine, taking into account estimated savings under contracts with carriers and fiscal intermediaries and other factors that the Secretary finds appropriate. Paragraph (1), the first sentence of paragraph (2)(A), paragraph (2)(B), paragraph (3)(C), paragraph (3)(D), and paragraph (3)(E) of section 1842(b) shall apply to the entity.”

(b) CONFORMING AMENDMENTS.—(1) Section 1882(c)(1) (42 U.S.C. 1395ss(c)(1)) is amended by inserting “(except as otherwise provided by subsection (t))” before the semicolon.

(2) Section 1882(b)(1) (42 U.S.C. 1395ss(b)(1)), as previously amended, is amended—

(A) in subparagraph (A), by inserting “, except as otherwise provided by subparagraph (H)” before the semicolon;

(B) by striking “and” at the end of subparagraph (F);

(C) by inserting “and” at the end of subparagraph (G); and

(D) by adding after subparagraph (G) the following:

“(H) in the case of a policy that meets the standards under subparagraph (A) except that benefits under the policy are limited to items and services furnished by certain entities (or reduced benefits are provided when items or services are furnished by other entities), provides for the application of requirements equal to or more stringent than the requirements under subsection (t).”

(3) The first sentence of section 1154(a)(4)(B) (42 U.S.C. 1320c-3(a)(4)(B)) is amended by inserting “(or subject to review under section 1882(t))” after “section 1876”.

(c) **EFFECTIVE DATE.**—The amendments made by this section shall only apply in 15 States (as determined by the Secretary of Health and Human Services) and only during the 3-year period beginning with 1992.

42 USC 1320c-3
note.

(d) **EVALUATION.**—The Secretary of Health and Human Services shall conduct an evaluation of the amendments made by this section and shall report to Congress on such evaluation by not later than January 1, 1995.

42 USC 1395ss
note.

SEC. 4359. HEALTH INSURANCE ADVISORY SERVICE FOR MEDICARE BENEFICIARIES.

42 USC 1395b-3.

(a) **IN GENERAL.**—The Secretary of Health and Human Services shall establish a health insurance advisory service program (in this section referred to as the “beneficiary assistance program”) to assist medicare-eligible individuals with the receipt of services under the medicare and medicaid programs and other health insurance programs.

(b) **OUTREACH ELEMENTS.**—The beneficiary assistance program shall provide assistance—

(1) through operation using local Federal offices that provide information on the medicare program,

(2) using community outreach programs, and

(3) using a toll-free telephone information service.

(c) **ASSISTANCE PROVIDED.**—The beneficiary assistance program shall provide for information, counseling, and assistance for medicare-eligible individuals with respect to at least the following:

(1) With respect to the medicare program—

(A) eligibility,

(B) benefits (both covered and not covered),

(C) the process of payment for services,

(D) rights and process for appeals of determinations,

(E) other medicare-related entities (such as peer review organizations, fiscal intermediaries, and carriers), and

(F) recent legislative and administrative changes in the medicare program.

(2) With respect to the medicaid program—

(A) eligibility, benefits, and the application process,

(B) linkages between the medicaid and medicare programs, and

(C) referral to appropriate State and local agencies involved in the medicaid program.

(3) With respect to medicare supplemental policies—

(A) the program under section 1882 of the Social Security Act and standards required under such program,

(B) how to make informed decisions on whether to purchase such policies and on what criteria to use in evaluating different policies,

(C) appropriate Federal, State, and private agencies that provide information and assistance in obtaining benefits under such policies, and

(D) other issues deemed appropriate by the Secretary.

The beneficiary assistance program also shall provide such other services as the Secretary deems appropriate to increase beneficiary understanding of, and confidence in, the medicare program and to improve the relationship between beneficiaries and the program.

(d) EDUCATIONAL MATERIAL.—The Secretary, through the Administrator of the Health Care Financing Administration, shall develop appropriate educational materials and other appropriate techniques to assist employees in carrying out this section.

(e) NOTICE TO BENEFICIARIES.—The Secretary shall take such steps as are necessary to assure that medicare-eligible beneficiaries and the general public are made aware of the beneficiary assistance program.

(f) REPORT.—The Secretary shall include, in an annual report transmitted to the Congress, a report on the beneficiary assistance program and on other health insurance informational and counseling services made available to medicare-eligible individuals. The Secretary shall include in the report recommendations for such changes as may be desirable to improve the relationship between the medicare program and medicare-eligible individuals.

42 USC 1395b-4.

SEC. 4360. HEALTH INSURANCE INFORMATION, COUNSELING, AND ASSISTANCE GRANTS.

(a) GRANTS.—The Secretary of Health and Human Services (in this section referred to as the “Secretary”) shall make grants to States, with approved State regulatory programs under section 1882 of the Social Security Act, that submit applications to the Secretary that meet the requirements of this section for the purpose of providing information, counseling, and assistance relating to the procurement of adequate and appropriate health insurance coverage to individuals who are eligible to receive benefits under title XVIII of the Social Security Act (in this section referred to as “eligible individuals”). The Secretary shall prescribe regulations to establish a minimum level of funding for a grant issued under this section.

(b) GRANT APPLICATIONS.—

(1) In submitting an application under this section, a State may consolidate and coordinate an application that consists of parts prepared by more than one agency or department of such State.

(2) As part of an application for a grant under this section, a State shall submit a plan for a State-wide health insurance information, counseling, and assistance program. Such program shall—

(A) establish or improve upon a health insurance information, counseling, and assistance program that pro-

vides counseling and assistance to eligible individuals in need of health insurance information, including—

(i) information that may assist individuals in obtaining benefits and filing claims under titles XVIII and XIX of the Social Security Act;

(ii) policy comparison information for medicare supplemental policies (as described in section 1882(g)(1) of the Social Security Act ²⁹ and information that may assist individuals in filing claims under such medicare supplemental policies;

(iii) information regarding long-term care insurance; and

(iv) information regarding other types of health insurance benefits that the Secretary determines to be appropriate;

(B) in conjunction with the health insurance information, counseling, and assistance program described in subparagraph (A), establish a system of referral to appropriate Federal or State departments or agencies for assistance with problems related to health insurance coverage (including legal problems), as determined by the Secretary;

(C) provide for a sufficient number of staff positions (including volunteer positions) necessary to provide the services of the health insurance information, counseling, and assistance program;

(D) provide assurances that staff members (including volunteer staff members) of the health insurance information, counseling, and assistance program have no conflict of interest in providing the services described in subparagraph (A);

(E) provide for the collection and dissemination of timely and accurate health care information to staff members;

(F) provide for training programs for staff members (including volunteer staff members);

(G) provide for the coordination of the exchange of health insurance information between the staff of departments and agencies of the State government and the staff of the health insurance information, counseling, and assistance program;

(H) make recommendations concerning consumer issues and complaints related to the provision of health care to agencies and departments of the State government and the Federal Government responsible for providing or regulating health insurance;

(I) establish an outreach program to provide the health insurance information and counseling described in subparagraph (A) and the assistance described in subparagraph (B) to eligible individuals; and

(J) demonstrate, to the satisfaction of the Secretary, an ability to provide the counseling and assistance required under this section.

(c) SPECIAL GRANTS.—

(1) A State that is conducting a health insurance information, counseling, and assistance program that is substantially similar to a program described in subsection (b)(2) shall, as a requirement for eligibility for a grant under this section, demonstrate, to the satisfaction of the Secretary, that such State shall main-

²⁹ So in original. Probably should be "Act)".

tain the activities of such program at least at the level that such activities were conducted immediately preceding the date of the issuance of any grant during the period of time covered by such grant under this section and that such activities will continue to be maintained at such level.

(2) If the Secretary determines that the existing health insurance information, counseling, and assistance program is substantially similar to a program described in subsection (b)(2), the Secretary may waive some or all of the requirements described in such subsection and issue a grant to the State for the purpose of increasing the number of services offered by the health insurance information, counseling, and assistance program, experimenting with new methods of outreach in conducting such program, or expanding such program to geographic areas of the State not previously served by the program.

(d) **CRITERIA FOR ISSUING GRANTS.**—In issuing a grant under this section, the Secretary shall consider—

(1) the commitment of the State to carrying out the health insurance information, counseling, and assistance program described in subsection (b)(2), including the level of cooperation demonstrated—

(A) by the office of the chief insurance regulator of the State, or the equivalent State entity;

(B) other officials of the State responsible for overseeing insurance plans issued by nonprofit hospital and medical service associations; and

(C) departments and agencies of such State responsible for—

(i) administering funds under title XIX of the Social Security Act, and

(ii) administering funds appropriated under the Older Americans Act;

(2) the population of eligible individuals in such State as a percentage of the population of such State; and

(3) in order to ensure the needs of rural areas in such State, the relative costs and special problems associated with addressing the special problems of providing health care information, counseling, and assistance to the rural areas of such State.

(e) **ANNUAL STATE REPORT.**—A State that receives a grant under subsection (c) or (d) ³⁰ shall, not later than 180 days after receiving such grant, and annually thereafter, issue an annual report to the Secretary that includes information concerning—

(1) the number of individuals served by the State-wide health insurance information, counseling and assistance program of such State;

(2) an estimate of the amount of funds saved by the State, and by eligible individuals in the State, in the implementation of such program; and

(3) the problems that eligible individuals in such State encounter in procuring adequate and appropriate health care coverage.

(f) **REPORT TO CONGRESS.**—Not later than 180 days after the date of the enactment of this section, and annually thereafter, the Secretary shall issue a report to the Committee on Finance of the Senate, the Special Committee on Aging of the Senate, the Committee on Ways and Means of the House of Representatives, the Committee on Energy and Commerce of the House of Representa-

³⁰ So in original. Probably should be "(a) or (c)".

tives, and the Select Committee on Aging of the House of Representatives that—

(1) summarizes the allocation of funds authorized for grants under this section and the expenditure of such funds;

(2) summarizes the scope and content of training conferences convened under this section;

(3) outlines the problems that eligible individuals encounter in procuring adequate and appropriate health care coverage;

(4) makes recommendations that the Secretary determines to be appropriate to address the problems described in paragraph (3); and

(5) in the case of the report issued 2 years after the date of enactment of this section, evaluates the effectiveness of counseling programs established under this program, and makes recommendations regarding continued authorization of funds for these purposes.

(f) **AUTHORIZATION OF APPROPRIATIONS FOR GRANTS.**—There are authorized to be appropriated, in equal parts from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund, \$10,000,000 for each of fiscal years 1991, 1992, and 1993, to fund the grant programs described in this section.

SEC. 4361. MEDICARE AND MEDIGAP INFORMATION BY TELEPHONE.

(a) **IN GENERAL.**—Title XVIII (42 U.S.C. 1395 et seq.) is amended by inserting after section 1888 the following:

“MEDICARE AND MEDIGAP INFORMATION BY TELEPHONE

“SEC. 1889. The Secretary shall provide information via a toll-free telephone number on the programs under this title and on medicare supplemental policies as defined in section 1882(g)(1) (including the relationship of State programs under title XIX to such policies).”.

(b) **DEMONSTRATION PROJECTS.**—The Secretary of Health and Human Services is authorized to conduct demonstration projects in up to 5 States for the purpose of establishing statewide toll-free telephone numbers for providing information on medicare benefits, medicare supplemental policies available in the State, and benefits under the State medicaid program.

Subtitle B—Medicaid

PART 1—REDUCTION IN SPENDING

Sec. 4401. Reimbursement for prescribed drugs.

Sec. 4402. Requiring medicaid payment of premiums and cost-sharing for enrollment under group health plans where cost-effective.

PART 2—PROTECTION OF LOW-INCOME MEDICARE BENEFICIARIES

Sec. 4501. Phased-in extension of medicaid payments for medicare premiums for certain individuals with income below 120 percent of the official poverty line.

PART 3—IMPROVEMENTS IN CHILD HEALTH

Sec. 4601. Medicaid child health provisions.

Sec. 4602. Mandatory use of outreach locations other than welfare offices.

Sec. 4603. Mandatory continuation of benefits throughout pregnancy or first year of life.

Sec. 4604. Adjustment in payment for hospital services furnished to low-income children under the age of 6 years.

Sec. 4605. Presumptive eligibility.

Sec. 4606. Role in paternity determinations.

42 USC 1395zz.

42 USC 1395zz
note.

Sec. 4607. Report and transition on errors in eligibility determinations.

PART 4—MISCELLANEOUS

SUBPART A—PAYMENTS

- Sec. 4701. State medicaid matching payments through voluntary contributions and State taxes.
- Sec. 4702. Disproportionate share hospitals: counting of inpatient days.
- Sec. 4703. Disproportionate share hospitals: alternative State payment adjustments and systems.
- Sec. 4704. Federally-qualified health centers.
- Sec. 4705. Hospice payments.
- Sec. 4706. Limitation on disallowances or deferral of Federal financial participation for certain inpatient psychiatric hospital services for individuals under age 21.
- Sec. 4707. Treatment of interest on Indiana disallowance.
- Sec. 4708. Billing for services of substitute physician.

SUBPART B—ELIGIBILITY AND COVERAGE

- Sec. 4711. Home and community-based care as optional service.
- Sec. 4712. Community supported living arrangements services.
- Sec. 4713. Providing Federal medical assistance for payments for premiums for "COBRA" continuation coverage where cost effective.
- Sec. 4714. Provisions relating to spousal impoverishment.
- Sec. 4715. Disregarding German reparation payments from post-eligibility treatment of income under the medicaid program.
- Sec. 4716. Amendments relating to medicaid transition provision.
- Sec. 4717. Clarifying effect of hospice election.
- Sec. 4718. Medically needy income levels for certain 1-member families.
- Sec. 4719. Codification of coverage of rehabilitation services.
- Sec. 4720. Personal care services for Minnesota.
- Sec. 4721. Medicaid coverage of personal care services outside the home.
- Sec. 4722. Medicaid coverage of alcoholism and drug dependency treatment services.
- Sec. 4723. Medicaid spenddown option.
- Sec. 4424. Optional State medicaid disability determinations independent of the Social Security Administration.

SUBPART C—HEALTH MAINTENANCE ORGANIZATIONS

- Sec. 4731. Regulation of incentive payments to physicians.
- Sec. 4732. Special rules.
- Sec. 4733. Extension and expansion of Minnesota prepaid medicaid demonstration project.
- Sec. 4734. Treatment of certain county-operated health insuring organizations.

SUBPART D—DEMONSTRATION PROJECTS AND HOME AND COMMUNITY-BASED WAIVERS

- Sec. 4741. Home and community-based waivers.
- Sec. 4742. Timely payment under waivers of freedom of choice of hospital services.
- Sec. 4744. Provisions relating to frail elderly demonstration project waivers.
- Sec. 4745. Demonstration projects to study the effect of allowing States to extend medicaid coverage to certain low-income families not otherwise qualified to receive medicaid benefits.
- Sec. 4746. Medicaid respite demonstration project extended.
- Sec. 4747. Demonstration project to provide medicaid coverage for HIV-positive individuals.

SUBPART E—MISCELLANEOUS

- Sec. 4751. Requirements for advanced directives under State plans for medical assistance.
- Sec. 4752. Improvement in quality of physician services.
- Sec. 4753. Clarification of authority of Inspector General.
- Sec. 4754. Notice to State medical boards when adverse actions taken.
- Sec. 4755. Miscellaneous provisions.

PART 5—PROVISIONS RELATING TO NURSING HOME REFORM

- Sec. 4801. Technical corrections relating to nursing home reform.

PART 1—REDUCTIONS IN SPENDING**SEC. 4401. REIMBURSEMENT FOR PRESCRIBED DRUGS.****(a) IN GENERAL.—**

(1) DENIAL OF FEDERAL FINANCIAL PARTICIPATION UNLESS REBATE AGREEMENTS AND DRUG USE REVIEW IN EFFECT.—Section 1903(i) (42 U.S.C. 1396b(i)) is amended—

(A) by striking the period at the end of paragraph (9) and inserting “; or”, and

(B) by inserting after paragraph (9) the following new paragraph:

“(10) with respect to covered outpatient drugs of a manufacturer dispensed in any State unless, (A) except as provided in section 1927(a)(3), the manufacturer complies with the rebate requirements of section 1927(a) with respect to the drugs so dispensed in all States, and (B) effective January 1, 1993, the State provides for drug use review in accordance with section 1927(g).”.

(2) PROHIBITING STATE PLAN DRUG ACCESS LIMITATIONS FOR DRUGS COVERED UNDER A REBATE AGREEMENT.—Section 1902(a) of such Act (42 U.S.C. 1396a(a)) is amended—

(A) by striking “and” at the end of paragraph (52),

(B) by striking the period at the end of paragraph (53) and inserting “; and”, and

(C) by inserting after paragraph (53) the following new paragraph:

“(54)(A) provide that, any formulary or similar restriction (except as provided in section 1927(d)) on the coverage of covered outpatient drugs under the plan shall permit the coverage of covered outpatient drugs of any manufacturer which has entered into and complies with an agreement under section 1927(a), which are prescribed for a medically accepted indication (as defined in subsection 1927(k)(6)), and

“(B) comply with the reporting requirements of section 1927(b)(2)(A) and the requirements of subsections (d) and (g) of section 1927.”.

(3) REBATE AGREEMENTS FOR COVERED OUTPATIENT DRUGS, DRUG USE REVIEW, AND RELATED PROVISIONS.—Title XIX of the Social Security Act is amended by redesignating section 1927 as section 1928 and by inserting after section 1926 the following new section:

42 USC 1396s.

“PAYMENT FOR COVERED OUTPATIENT DRUGS

“SEC. 1927. (a) REQUIREMENT FOR REBATE AGREEMENT.—

42 USC 1396r-8.

“(1) **IN GENERAL.—**In order for payment to be available under section 1903(a) for covered outpatient drugs of a manufacturer, the manufacturer must have entered into and have in effect a rebate agreement described in subsection (b) with the Secretary, on behalf of States (except that, the Secretary may authorize a State to enter directly into agreements with a manufacturer). Any agreement between a State and a manufacturer prior to April 1, 1991, shall be deemed to have been entered into on January 1, 1991, and payment to such manufacturer shall be retroactively calculated as if the agreement between the manufacturer and the State had been entered into on January 1, 1991. If a manufacturer has not entered into such an agreement

before March 1, 1991, such an agreement, subsequently entered into, shall not be effective until the first day of the calendar quarter that begins more than 60 days after the date the agreement is entered into.

“(2) **EFFECTIVE DATE.**—Paragraph (1) shall first apply to drugs dispensed under this title on or after January 1, 1991.

“(3) **AUTHORIZING PAYMENT FOR DRUGS NOT COVERED UNDER REBATE AGREEMENTS.**—Paragraph (1), and section 1903(i)(10)(A), shall not apply to the dispensing of a single source drug or innovator multiple source drug if (A)(i) the State has made a determination that the availability of the drug is essential to the health of beneficiaries under the State plan for medical assistance; (ii) such drug has been given a rating of 1-A by the Food and Drug Administration; and (iii)(I) the physician has obtained approval for use of the drug in advance of its dispensing in accordance with a prior authorization program described in subsection (d), or (II) the Secretary has reviewed and approved the State’s determination under subparagraph (A); or (B) the Secretary determines that in the first calendar quarter of 1991, there were extenuating circumstances.

“(4) **EFFECT ON EXISTING AGREEMENTS.**—In the case of a rebate agreement in effect between a State and a manufacturer on the date of the enactment of this section, such agreement, for the initial agreement period specified therein, shall be considered to be a rebate agreement in compliance with this section with respect to that State, if the State agrees to report to the Secretary any rebates paid pursuant to the agreement and such agreement provides for a minimum aggregate rebate of 10 percent of the State’s total expenditures under the State plan for coverage of the manufacturer’s drugs under this title. If, after the initial agreement period, the State establishes to the satisfaction of the Secretary that an agreement in effect on the date of the enactment of this section provides for rebates that are at least as large as the rebates otherwise required under this section, and the State agrees to report any rebates under the agreement to the Secretary, the agreement shall be considered to be a rebate agreement in compliance with the section for the renewal periods of such agreement.

“(b) **TERMS OF REBATE AGREEMENT.**—

“(1) **PERIODIC REBATES.**—

“(A) **IN GENERAL.**—A rebate agreement under this subsection shall require the manufacturer to provide, to each State plan approved under this title, a rebate each calendar quarter (or periodically in accordance with a schedule specified by the Secretary) in an amount specified in subsection (c) for covered outpatient drugs of the manufacturer dispensed under the plan during the quarter (or such other period as the Secretary may specify). Such rebate shall be paid by the manufacturer not later than 30 days after the date of receipt of the information described in paragraph (2) for the period involved.

“(B) **OFFSET AGAINST MEDICAL ASSISTANCE.**—Amounts received by a State under this section (or under an agreement authorized by the Secretary under subsection (a)(1) or an agreement described in subsection (a)(4)) in any quarter shall be considered to be a reduction in the amount ex-

pended under the State plan in the quarter for medical assistance for purposes of section 1903(a)(1).

“(2) STATE PROVISION OF INFORMATION.—

“(A) STATE RESPONSIBILITY.—Each State agency under this title shall report to each manufacturer not later than 60 days after the end of each calendar quarter and in a form consistent with a standard reporting format established by the Secretary, information on the total number of dosage units of each covered outpatient drug dispensed under the plan during the quarter, and shall promptly transmit a copy of such report to the Secretary.

“(B) AUDITS.—A manufacturer may audit the information provided (or required to be provided) under subparagraph (A). Adjustments to rebates shall be made to the extent that information indicates that utilization was greater or less than the amount previously specified.

“(3) MANUFACTURER PROVISION OF PRICE INFORMATION.—

“(A) IN GENERAL.—Each manufacturer with an agreement in effect under this section shall report to the Secretary—

“(i) not later than 30 days after the last day of each quarter (beginning on or after January 1, 1991), on the average manufacturer price (as defined in subsection (k)(1)) and, (for single source drugs and innovator multiple source drugs), the manufacturer’s best price (as defined in subsection (c)(2)(B)) for covered outpatient drugs for the quarter, and

“(ii) not later than 30 days after the date of entering into an agreement under this section on the average manufacturer price (as defined in subsection (k)(1)) as of October 1, 1990³¹ for each of the manufacturer’s covered outpatient drugs.

“(B) VERIFICATION SURVEYS OF AVERAGE MANUFACTURER PRICE.—The Secretary may survey wholesalers and manufacturers that directly distribute their covered outpatient drugs, when necessary, to verify manufacturer prices reported under subparagraph (A). The Secretary may impose a civil monetary penalty in an amount not to exceed \$100,000 on a wholesaler, manufacturer, or direct seller, if the wholesaler, manufacturer, or direct seller of a covered outpatient drug refuses a request for information about charges or prices by the Secretary in connection with a survey under this subparagraph or knowingly provides false information. The provisions of section 1128A (other than subsections (a) (with respect to amounts of penalties or additional assessments) and (b)) shall apply to a civil money penalty under this subparagraph in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

“(C) PENALTIES.—

“(i) FAILURE TO PROVIDE TIMELY INFORMATION.—In the case of a manufacturer with an agreement under this section that fails to provide information required under subparagraph (A) on a timely basis, the amount of the penalty shall be increased by \$10,000 for each day in which such information has not been provided and such amount shall be paid to the Treasury, and, if such

³¹ So in original. Probably should be “1990.”

information is not reported within 90 days of the deadline imposed, the agreement shall be suspended for services furnished after the end of such 90-day period and until the date such information is reported (but in no case shall such suspension be for a period of less than 30 days).

“(ii) FALSE INFORMATION.—Any manufacturer with an agreement under this section that knowingly provides false information is subject to a civil money penalty in an amount not to exceed \$100,000 for each item of false information. Such civil money penalties are in addition to other penalties as may be prescribed by law. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under this subparagraph in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

“(D) CONFIDENTIALITY OF INFORMATION.—Notwithstanding any other provision of law, information disclosed by manufacturers or wholesalers under this paragraph is confidential and shall not be disclosed by the Secretary or a State agency (or contractor therewith) in a form which discloses the identity of a specific manufacturer or wholesaler, prices charged for drugs by such manufacturer or wholesaler, except as the Secretary determines to be necessary to carry out this section and to permit the Comptroller General to review the information provided.

“(4) LENGTH OF AGREEMENT.—

“(A) IN GENERAL.—A rebate agreement shall be effective for an initial period of not less than 1 year and shall be automatically renewed for a period of not less than one year unless terminated under subparagraph (B).

“(B) TERMINATION.—

“(i) BY THE SECRETARY.—The Secretary may provide for termination of a rebate agreement for violation of the requirements of the agreement or other good cause shown. Such termination shall not be effective earlier than 60 days after the date of notice of such termination. The Secretary shall provide, upon request, a manufacturer with a hearing concerning such a termination, but such hearing shall not delay the effective date of the termination.

“(ii) BY A MANUFACTURER.—A manufacturer may terminate a rebate agreement under this section for any reason. Any such termination shall not be effective until such period after the date of the notice as the Secretary may provide (but not beyond the term of the agreement).

“(iii) EFFECTIVENESS OF TERMINATION.—Any termination under this subparagraph shall not affect rebates due under the agreement before the effective date of its termination.

“(C) DELAY BEFORE REENTRY.—In the case of any rebate agreement with a manufacturer under this section which is terminated, another such agreement with the manufacturer (or a successor manufacturer) may not be entered into until a period of 1 calendar quarter has elapsed since the

date of the termination, unless the Secretary finds good cause for an earlier reinstatement of such an agreement.

“(c) AMOUNT OF REBATE.—

“(1) BASIC REBATE FOR SINGLE SOURCE DRUGS AND INNOVATOR MULTIPLE SOURCE DRUGS.—With respect to single source drugs and innovator multiple source drugs, each manufacturer shall remit a basic rebate to the State medical assistance plan. Except as otherwise provided in this subsection, the amount of the rebate to a State for a calendar quarter (or other period specified by the Secretary) with respect to each dosage form and strength of single source drugs and innovator multiple source drugs shall be equal to the product of—

“(A) the total number of units of each dosage form and strength dispensed under the plan under this title in the quarter (or other period) reported by the State under subsection (b)(2); and

“(B)(i) for quarters (or periods) beginning after December 31, 1990, and before January 1, 1993, the greater of—

“(I) the difference between the average manufacturer price (after deducting customary prompt payment discounts) and 87.5 percent of such price for the quarter (or other period), or

“(II) the difference between the average manufacturer price for a drug and the best price (as defined in paragraph (2)(B)) for such quarter (or period) for such drug (except that for calendar quarters beginning after December 31, 1990, and ending before January 1, 1992, the rebate shall not exceed 25 percent of the average manufacturer price, and for calendar quarters beginning after December 31, 1991, and ending before January 1, 1993, the rebate shall not exceed 50 percent of the average manufacturer price); and

“(ii) for quarters (or other periods) beginning after December 31, 1992, the greater of—

“(I) the difference between the average manufacturer price for a drug and 85 percent of such price, or

“(II) the difference between the average manufacturer price for a drug and the best price (as defined in paragraph (2)(B)) for such quarter (or period) for such drug.

“(C) For the purposes of this paragraph, the term ‘best price’ means, with respect to a single source drug or innovator multiple source drug of a manufacturer, the lowest price available from the manufacturer to any wholesaler, retailer, nonprofit entity, or governmental entity within the United States (excluding depot prices and single award contract prices, as defined by the Secretary, of any agency of the Federal Government). The best price shall be inclusive of cash discounts, free goods, volume discounts, and rebates (other than rebates under this section) and shall be determined without regard to special packaging, labeling, or identifiers on the dosage form or product or package, and shall not take into account prices that are merely nominal in amount;³²

“(D) In the case of a covered outpatient drug approved for marketing after October 1, 1990, any reference in this paragraph to ‘October 1, 1990’ shall be a reference to the first day of the first month during which the drug was marketed.

³² So in original. Probably should be “.”.

“(2) ADDITIONAL REBATE FOR SINGLE SOURCE AND INNOVATOR MULTIPLE SOURCE DRUGS.—(A) Each manufacturer shall remit an additional rebate to the State medical assistance plan in an amount equal to:

“(i) For calendar quarters (or other periods) beginning after December 31, 1990 and ending before January 1, 1994—

“(I) the total number of each dosage form and strength of a single source or innovator multiple source drug dispensed during the calendar quarter (or other period); multiplied by

“(II)(aa) the average manufacturer price for each dosage form and strength, minus

“(bb) the average manufacturer price for each such dosage form and strength in effect on October 1, 1990, increased by the percentage increase in the Consumer Price Index for all urban consumers (U.S. average) from October 1, 1990, to the month before the beginning of the calendar quarter (or other period) involved;³³

“(ii) For calendar quarters (or other periods) beginning after December 31, 1993—

“(I) the total number of each dosage form and strength of a single source or innovative multiple source drug dispensed during the calendar quarter (or other period); multiplied by

“(II) the amount, if any, by which the weighted average manufacturer price for single source and innovator multiple source drugs of a manufacturer exceeds the weighted average manufacturer price for the manufacturer as of October 1, 1990, increased by the percentage increase in the Consumer Price Index for all urban consumers (U.S. average) from October 1, 1990, to the month before the beginning of the calendar quarter (or other period) involved.

“(B)(i) For the purposes of subparagraph (A)(ii), the term ‘weighted average manufacturer price’ means (with respect to a calendar quarter or other period) the ratio of—

“(I) the sum of the products (for all covered drugs of the manufacturer purchased under a State program under this title) of—

“(aa) the average manufacturer price for each such covered drug; and

“(bb) the number of units of the covered drug sold to any State program under this title during such period, to

“(II) the total number of units of all such covered drugs sold under a State program under this title in such period, except that the Secretary may exclude certain new drugs from the calculation of the weighted average if the inclusion of any such drug in such calculation has the effect of—

“(aa) reducing the rebate otherwise calculated pursuant to subparagraph (A)(ii); or

“(bb) increasing the rebate otherwise calculated pursuant to subparagraph (A)(ii) (in cases where such calculation under the conditions outlined in clause (ii)).³⁴

³³ So in original. Probably should be “.”.

³⁴ So in original. Probably should be “(ii)”.

“(ii)(I) The Secretary may exclude drugs approved by the Food and Drug Administration on or after October 1, 1990, from the calculation of weighted average manufacturer price if inclus³⁵ manufacturer demonstrates through a petition, in a form and manner prescribed by the Secretary, undue hardship on such manufacturer as a result of the inclusion of such drug in such calculation).³⁶

“(II) The Secretary may promulgate guidelines to restrict the conditions under which the Secretary may consider such petitions.

“(C) For each of 8 calendar quarters beginning after December 31, 1991, the Secretary shall compare the aggregate amount of the rebates under subparagraph (A)(i) to the aggregate amount of rebates under subparagraph (A)(ii). Based on any such comparison, the Secretary may propose and utilize an alternative formula for the purpose of calculating an aggregate rebate.

“(3) REBATE FOR OTHER DRUGS.—The amount of the rebate to a State for a calendar quarter (or other period specified by the Secretary) with respect to covered outpatient drugs (other than single source drugs and innovator multiple source drugs) shall be equal to the product of—

“(A) the applicable percentage (as described in paragraph (4)³⁷ of the average manufacturer price for each dosage form and strength of such drugs (after deducting customary prompt payment discounts) for the quarter (or other period), and

“(B) the number of units of such form and dosage dispensed under the plan under this title in the quarter (or other period) reported by the State under subsection (b)(2).

“(4) For the purposes of paragraph (3), the applicable percentage is—

“(A) with respect to calendar quarters beginning after December 31, 1990, and ending before January 1, 1994, 10 percent; and

“(B) with respect to calendar quarters beginning on or after December 31, 1993, 11 percent.

“(d) LIMITATIONS ON COVERAGE OF DRUGS.—

“(1) PERMISSIBLE RESTRICTIONS.—(A) Except as provided in paragraph (6), a State may subject to prior authorization any covered outpatient drug. Any such prior authorization program shall comply with the requirements of paragraph (5).

“(B) A State may exclude or otherwise restrict coverage of a covered outpatient drug if—

“(i) the prescribed use is not for a medically accepted indication (as defined in (k)(6));

“(ii) the drug is contained in the list referred to in paragraph (2); or

“(iii) the drug is subject to such restrictions pursuant to an agreement between a manufacturer and a State authorized by the Secretary under subsection (a)(1) or in effect pursuant to subsection (a)(4).

“(2) LIST OF DRUGS SUBJECT TO RESTRICTION.—The following drugs or classes of drugs, or their medical uses, may be excluded from coverage or otherwise restricted:

“(A) Agents when used for anorexia or weight gain.

“(B) Agents when used to promote fertility.

³⁵ So in original. The “inclus” probably should be “the”.

³⁶ So in original. Probably should be “calculation.”.

³⁷ So in original. Probably should be “(4)”.

“(C) Agents when used for cosmetic purposes or hair growth.

“(D) Agents when used for the symptomatic relief of cough and colds.

“(E) Agents when used to promote smoking cessation.

“(F) Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations.

“(G) Nonprescription drugs.

“(H) Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee.

“(I) Drugs described in section 107(c)(3) of the Drug Amendments of 1962 and identical, similar, or related drugs (within the meaning of section 310.6(b)(1) of title 21 of the Code of Federal Regulations (‘DESI’ drugs)).

“(J) Barbiturates.

“(K) Benzodiazepines.

“(3) UPDATE OF DRUG LISTINGS.—The Secretary shall (except with respect to new drugs approved by the FDA for the first 6 months following the date of approval of such drugs shall not be subject to being listed in paragraph (2) under the provisions of this paragraph), by regulation, periodically update the list of drugs described in paragraph (2) or classes of drugs, or their medical uses, which the Secretary has determined, based on data collected by surveillance and utilization review programs of State medical assistance programs, to be subject to clinical abuse or inappropriate use.

“(4) INNOVATOR MULTIPLE-SOURCE DRUGS.—Innovator multiple-source drugs shall be treated under applicable State and Federal law and regulation.

“(5) PRIOR AUTHORIZATION PROGRAMS.—A State plan under this title may not require, as a condition of coverage or payment for a covered outpatient drug for which Federal financial participation is available in accordance with this section, the approval of the drug before its dispensing for any medically accepted indication (as defined in subsection (k)(6)) unless the system providing for such approval—

“(A) provides response by telephone or other telecommunication device within 24 hours of a request for prior authorization; and

“(B) except with respect to the drugs on the list referred to in paragraph (2), provides for the dispensing of at least a 72-hour supply of a covered outpatient prescription drug in an emergency situation (as defined by the Secretary).

“(6) TREATMENT OF NEW DRUGS.—A State may not exclude for coverage, subject to prior authorization, or otherwise restrict any new biological or drug approved by the Food and Drug Administration after the date of enactment of this section, for a period of 6 months after such approval.

“(7) OTHER PERMISSIBLE RESTRICTIONS.—A State may impose limitations, with respect to all such drugs in a therapeutic class, on the minimum or maximum quantities per prescription or on the number of refills, provided such limitations are necessary to discourage waste. Nothing in this section shall restrict the ability of a State to address individual instances of fraud or abuse in any manner authorized under the Social Security Act.

“(8) DELAYED EFFECTIVE DATE.—The provisions of paragraph (5) shall become effective with respect to drugs dispensed under this title on or after July 1, 1991.

“(e) DENIAL OF FEDERAL FINANCIAL PARTICIPATION IN CERTAIN CASES.—The Secretary shall provide that no payment shall be made to a State under section 1903(a) for an innovator multiple-source drug dispensed on or after July 1, 1991, if, under applicable State law, a less expensive noninnovator multiple source drug (other than the innovator multiple-source drug) could have been dispensed.

“(f) PHARMACY REIMBURSEMENT.—

“(1) NO REDUCTIONS IN REIMBURSEMENT LIMITS.—(A) During the period of time beginning on January 1, 1991, and ending on December 31, 1994, the Secretary may not modify by regulation the formula used to determine reimbursement limits described in the regulations under 42 CFR 447.331 through 42 CFR 447.334 (as in effect on the date of the enactment of the Omnibus Budget Reconciliation Act of 1990) to reduce such limits for covered outpatient drugs.

(B) ³⁸ During the period of time described in subparagraph (A), any State that was in compliance with the regulations described in subparagraph (A) may not reduce the limits for covered outpatient drugs described in subparagraph (A) or dispensing fees for such drugs.

“(2) ESTABLISHMENT OF UPPER PAYMENT LIMITS.—HCFA shall establish a Federal upper reimbursement limit for each multiple source drug for which the FDA has rated three or more products therapeutically and pharmaceutically equivalent, regardless of whether all such additional formulations are rated as such and shall use only such formulations when determining any such upper limit.

“(g) DRUG USE REVIEW.—

“(1) IN GENERAL.—

“(A) In order to meet the requirement of section 1903(i)(10)(B), a State shall provide, by not later than January 1, 1993, for a drug use review program described in paragraph (2) for covered outpatient drugs in order to assure that prescriptions (i) are appropriate, (ii) are medically necessary, and (iii) are not likely to result in adverse medical results. The program shall be designed to educate physicians and pharmacists to identify and reduce the frequency of patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care, among physicians, pharmacists, and patients, or associated with specific drugs or groups of drugs, as well as potential and actual severe adverse reactions to drugs including education on therapeutic appropriateness, overutilization and underutilization, appropriate use of generic products, therapeutic duplication, drug-disease contraindications, drug-drug interactions, incorrect drug dosage or duration of drug treatment, drug-allergy interactions, and clinical abuse/misuse.

“(B) The program shall assess data on drug use against predetermined standards, consistent with the following:

“(i) compendia which shall consist of the following:

³⁸ So in original. Probably should be ““(B)””.

“(I) American Hospital Formulary Service Drug Information;

“(II) United States Pharmacopeia-Drug Information; and

“(III) American Medical Association Drug Evaluations; and

“(ii) the peer-reviewed medical literature.

“(C) The Secretary, under the procedures established in section 1903, shall pay to each State an amount equal to 75 per centum of so much of the sums expended by the State plan during calendar years 1991 through 1993 as the Secretary determines is attributable to the statewide adoption of a drug use review program which conforms to the requirements of this subsection.

“(D) States shall not be required to perform additional drug use reviews with respect to drugs dispensed to residents of nursing facilities which are in compliance with the drug regimen review procedures prescribed by the Secretary for such facilities in regulations implementing section 1919, currently at section 483.60 of title 42, Code of Federal Regulations.

“(2) DESCRIPTION OF PROGRAM.—Each drug use review program shall meet the following requirements for covered outpatient drugs:

“(A) PROSPECTIVE DRUG REVIEW.—(i) The State plan shall provide for a review of drug therapy before each prescription is filled or delivered to an individual receiving benefits under this title, typically at the point-of-sale or point of distribution. The review shall include screening for potential drug therapy problems due to therapeutic duplication, drug-disease contraindications, drug-drug interactions (including serious interactions with nonprescription or over-the-counter drugs), incorrect drug dosage or duration of drug treatment, drug-allergy interactions, and clinical abuse/misuse. Each State shall use the compendia and literature referred to in paragraph (1)(B) as its source of standards for such review.

“(ii) As part of the State’s prospective drug use review program under this subparagraph applicable State law shall establish standards for counseling of individuals receiving benefits under this title by pharmacists which includes at least the following:

“(I) The pharmacist must offer to discuss with each individual receiving benefits under this title or caregiver of such individual (in person, whenever practicable, or through access to a telephone service which is toll-free for long-distance calls) who presents a prescription, matters which in the exercise of the pharmacist’s professional judgment (consistent with State law respecting the provision of such information), the pharmacist deems significant including the following:

“(aa) The name and description of the medication.

“(bb) The route, dosage form, dosage, route of administration, and duration of drug therapy.

“(cc) Special directions and precautions for preparation, administration and use by the patient.

“(dd) Common severe side or adverse effects or interactions and therapeutic contraindications that may be encountered, including their avoidance, and the action required if they occur.

“(ee) Techniques for self-monitoring drug therapy.

“(ff) Proper storage.

“(gg) Prescription refill information.

“(hh) Action to be taken in the event of a missed dose.

“(II) A reasonable effort must be made by the pharmacist to obtain, record, and maintain at least the following information regarding individuals receiving benefits under this title:

“(aa) Name, address, telephone number, date of birth (or age) and gender.

“(bb) Individual history where significant, including disease state or states, known allergies and drug reactions, and a comprehensive list of medications and relevant devices.

“(cc) Pharmacist comments relevant to the individuals drug therapy.

Nothing in this clause shall be construed as requiring a pharmacist to provide consultation when an individual receiving benefits under this title or caregiver of such individual refuses such consultation.

“(B) RETROSPECTIVE DRUG USE REVIEW.—The program shall provide, through its mechanized drug claims processing and information retrieval systems (approved by the Secretary under section 1903(r)) or otherwise, for the ongoing periodic examination of claims data and other records in order to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care, among physicians, pharmacists and individuals receiving benefits under this title, or associated with specific drugs or groups of drugs.

“(C) APPLICATION OF STANDARDS.—The program shall, on an ongoing basis, assess data on drug use against explicit predetermined standards (using the compendia and literature referred to in subsection (1)(B) as the source of standards for such assessment) including but not limited to monitoring for therapeutic appropriateness, overutilization and underutilization, appropriate use of generic products, therapeutic duplication, drug-disease contraindications, drug-drug interactions, incorrect drug dosage or duration of drug treatment, and clinical abuse/misuse and, as necessary, introduce remedial strategies, in order to improve the quality of care and to conserve program funds or personal expenditures.

“(D) EDUCATIONAL PROGRAM.—The program shall, through its State drug use review board established under paragraph (3), either directly or through contracts with accredited health care educational institutions, State medical societies or State pharmacists associations/societies or other organizations as specified by the State, and using data

provided by the State drug use review board on common drug therapy problems, provide for active and ongoing educational outreach programs (including the activities described in paragraph (3)(C)(iii) of this subsection) to educate practitioners on common drug therapy problems with the aim of improving prescribing or dispensing practices.

“(3) STATE DRUG USE REVIEW BOARD.—

“(A) ESTABLISHMENT.—Each State shall provide for the establishment of a drug use review board (hereinafter referred to as the ‘DUR Board’) either directly or through a contract with a private organization.

“(B) MEMBERSHIP.—The membership of the DUR Board shall include health care professionals who have recognized knowledge and expertise in one or more of the following:

“(i) The clinically appropriate prescribing of covered outpatient drugs.

“(ii) The clinically appropriate dispensing and monitoring of covered outpatient drugs.

“(iii) Drug use review, evaluation, and intervention.

“(iv) Medical quality assurance.

The membership of the DUR Board shall be made up at least $\frac{1}{3}$ but no more than 51 percent licensed and actively practicing physicians and at least $\frac{1}{3}$ * * * licensed and actively practicing pharmacists.

“(C) ACTIVITIES.—The activities of the DUR Board shall include but not be limited to the following:

“(i) Retrospective DUR as defined in section (2)(B).

“(ii) Application of standards as defined in section (2)(C).

“(iii) Ongoing interventions for physicians and pharmacists, targeted toward therapy problems or individuals identified in the course of retrospective drug use reviews performed under this subsection. Intervention programs shall include, in appropriate instances, at least:

“(I) information dissemination sufficient to ensure the ready availability to physicians and pharmacists in the State of information concerning its duties, powers, and basis for its standards;

“(II) written, oral, or electronic reminders containing patient-specific or drug-specific (or both) information and suggested changes in prescribing or dispensing practices, communicated in a manner designed to ensure the privacy of patient-related information;

“(III) use of face-to-face discussions between health care professionals who are experts in rational drug therapy and selected prescribers and pharmacists who have been targeted for educational intervention, including discussion of optimal prescribing, dispensing, or pharmacy care practices, and follow-up face-to-face discussions; and

“(IV) intensified review or monitoring of selected prescribers or dispensers.

The Board shall re-evaluate interventions after an appropriate period of time to determine if the intervention im-

proved the quality of drug therapy, to evaluate the success of the interventions and make modifications as necessary.

“(D) ANNUAL REPORT.—Each State shall require the DUR Board to prepare a report on an annual basis. The State shall submit a report on an annual basis to the Secretary which shall include a description of the activities of the Board, including the nature and scope of the prospective and retrospective drug use review programs, a summary of the interventions used, an assessment of the impact of these educational interventions on quality of care, and an estimate of the cost savings generated as a result of such program. The Secretary shall utilize such report in evaluating the effectiveness of each State’s drug use review program.

“(h) ELECTRONIC CLAIMS MANAGEMENT.—

“(1) IN GENERAL.—In accordance with chapter 35 of title 44, United States Code (relating to coordination of Federal information policy), the Secretary shall encourage each State agency to establish, as its principal means of processing claims for covered outpatient drugs under this title, a point-of-sale electronic claims management system, for the purpose of performing on-line, real time eligibility verifications, claims data capture, adjudication of claims, and assisting pharmacists (and other authorized persons) in applying for and receiving payment.

“(2) ENCOURAGEMENT.—In order to carry out paragraph (1)—

“(A) for calendar quarters during fiscal years 1991 and 1992, expenditures under the State plan attributable to development of a system described in paragraph (1) shall receive Federal financial participation under section 1903(a)(3)(A)(i) (at a matching rate of 90 percent) if the State acquires, through applicable competitive procurement process in the State, the most cost-effective telecommunications network and automatic data processing services and equipment; and

“(B) the Secretary may permit, in the procurement described in subparagraph (A) in the application of part 433 of title 42, Code of Federal Regulations, and parts 95, 205, and 307 of title 45, Code of Federal Regulations, the substitution of the State’s request for proposal in competitive procurement for advance planning and implementation documents otherwise required.

“(i) ANNUAL REPORT.—

“(1) IN GENERAL.—Not later than May 1 of each year the Secretary shall transmit to the Committee on Finance of the Senate, the Committee on Energy and Commerce of the House of Representatives, and the Committees on Aging of the Senate and the House of Representatives a report on the the operation of this section in the preceding fiscal year.

“(2) DETAILS.—Each report shall include information on—

“(A) ingredient costs paid under this title for single source drugs, multiple source drugs, and nonprescription covered outpatient drugs;

“(B) the total value of rebates received and number of manufacturers providing such rebates;

“(C) how the size of such rebates compare with the size or rebates offered to other purchasers of covered outpatient drugs;

“(D) the effect of inflation on the value of rebates required under this section;

“(E) trends in prices paid under this title for covered outpatient drugs; and

“(F) Federal and State administrative costs associated with compliance with the provisions of this title.

“(j) EXEMPTION OF ORGANIZED HEALTH CARE SETTINGS.—(1) Covered outpatient drugs dispensed by * * * Health Maintenance Organizations, including those organizations that contract under section 1903(m), are not subject to the requirements of this section.

“(2) The State plan shall provide that a hospital (providing medical assistance under such plan) that dispenses covered outpatient drugs using drug formulary systems, and bills the plan no more than the hospital's purchasing costs for covered outpatient drugs (as determined under the State plan) shall not be subject to the requirements of this section.

“(3) Nothing in this subsection shall be construed as providing that amounts for covered outpatient drugs paid by the institutions described in this subsection should not be taken into account for purposes of determining the best price as described in subsection (c).

“(k) DEFINITIONS.—In this section—

“(1) AVERAGE MANUFACTURER PRICE.—The term ‘average manufacturer price’ means, with respect to a covered outpatient drug of a manufacturer for a calendar quarter, the average price paid to the manufacturer for the drug in the United States by wholesalers for drugs distributed to the retail pharmacy class of trade.

“(2) COVERED OUTPATIENT DRUG.—Subject to the exceptions in paragraph (3), the term ‘covered outpatient drug’ means—

“(A) of those drugs which are treated as prescribed drugs for purposes of section 1905(a)(12), a drug which may be dispensed only upon prescription (except as provided in paragraph (5)), and—

“(i) which is approved for safety and effectiveness as a prescription drug under section 505 or 507 of the Federal Food, Drug, and Cosmetic Act or which is approved under section 505(j) of such Act;

“(ii)(I) which was commercially used or sold in the United States before the date of the enactment of the Drug Amendments of 1962 or which is identical, similar, or related (within the meaning of section 310.6(b)(1) of title 21 of the Code of Federal Regulations) to such a drug, and (II) which has not been the subject of a final determination by the Secretary that it is a ‘new drug’ (within the meaning of section 201(p) of the Federal Food, Drug, and Cosmetic Act) or an action brought by the Secretary under section 301, 302(a), or 304(a) of such Act to enforce section 502(f) or 505(a) of such Act; or

“(iii)(I) which is described in section 107(c)(3) of the Drug Amendments of 1962 and for which the Secretary has determined there is a compelling justification for its medical need, or is identical, similar, or related (within the meaning of section 310.6(b)(1) of title 21 of the Code of Federal Regulations) to such a drug, and (II) for which the Secretary has not issued a notice of an opportunity for a hearing under section 505(e) of the

Federal Food, Drug, and Cosmetic Act on a proposed order of the Secretary to withdraw approval of an application for such drug under such section because the Secretary has determined that the drug is less than effective for some or all conditions of use prescribed, recommended, or suggested in its labeling; and

“(B) a biological product, other than a vaccine which—

“(i) may only be dispensed upon prescription,

“(ii) is licensed under section 351 of the Public Health Service Act, and

“(iii) is produced at an establishment licensed under such section to produce such product; and

“(C) insulin certified under section 506 of the Federal Food, Drug, and Cosmetic Act.

“(3) **LIMITING DEFINITION.**—The term ‘covered outpatient drug’ does not include any drug, biological product, or insulin provided as part of, or as incident to and in the same setting as, any of the following (and for which payment may be made under this title as part of payment for the following and not as direct reimbursement for the drug):

“(A) Inpatient hospital services.

“(B) Hospice services.

“(C) Dental services, except that drugs for which the State plan authorizes direct reimbursement to the dispensing dentist are covered outpatient drugs.

“(D) Physicians’ services.

“(E) Outpatient hospital services * * * *³⁹ emergency room visits.

“(F) Nursing facility services.

“(G) Other laboratory and x-ray services.

“(H) Renal dialysis.

Such term also does not include any such drug or product which is used for a medical indication which is not a medically accepted indication.

“(4) **NONPRESCRIPTION DRUGS.**—If a State plan for medical assistance under this title includes coverage of prescribed drugs as described in section 1905(a)(12) and permits coverage of drugs which may be sold without a prescription (commonly referred to as ‘over-the-counter’ drugs), if they are prescribed by a physician (or other person authorized to prescribe under State law), such a drug shall be regarded as a covered outpatient drug.

“(5) **MANUFACTURER.**—The term ‘manufacturer’ means any entity which is engaged in—

“(A) the production, preparation, propagation, compounding, conversion, or processing of prescription drug products, either directly or indirectly by extraction from substances of natural origin, or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis, or

“(B) in the packaging, repackaging, labeling, relabeling, or distribution of prescription drug products.

Such term does not include a wholesale distributor of drugs or a retail pharmacy licensed under State law.

“(6) **MEDICALLY ACCEPTED INDICATION.**—The term ‘medically accepted indication’ means any use for a covered outpatient drug which is approved under the Federal Food, Drug, and Cosmetic Act, which appears in peer-reviewed medical lit-

³⁹ So in original. Probably should be “services emergency”.

erature or which is accepted by one or more of the following compendia: the American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluations, and the United States Pharmacopeia-Drug Information.

“(7) MULTIPLE SOURCE DRUG; INNOVATOR MULTIPLE SOURCE DRUG; NONINNOVATOR MULTIPLE SOURCE DRUG; SINGLE SOURCE DRUG.—

“(A) DEFINED.—

“(i) MULTIPLE SOURCE DRUG.—The term ‘multiple source drug’ means, with respect to a calendar quarter, a covered outpatient drug (not including any drug described in paragraph (5)) for which there are 2 or more drug products which—

“(I) are rated as therapeutically equivalent (under the Food and Drug Administration’s most recent publication of ‘Approved Drug Products with Therapeutic Equivalence Evaluations’),

“(II) except as provided in subparagraph (B), are pharmaceutically equivalent and bioequivalent, as defined in subparagraph (C) and as determined by the Food and Drug Administration, and

“(III) are sold or marketed in the State during the period.

“(ii) INNOVATOR MULTIPLE SOURCE DRUG.—The term ‘innovator multiple source drug’ means a multiple source drug that was originally marketed under an original new drug application approved by the Food and Drug Administration.

“(iii) NONINNOVATOR MULTIPLE SOURCE DRUG.—The term ‘noninnovator multiple source drug’ means a multiple source drug that is not an innovator multiple source drug.

“(iv) SINGLE SOURCE DRUG.—The term ‘single source drug’ means a covered outpatient drug which is produced or distributed under an original new drug application approved by the Food and Drug Administration, including a drug product marketed by any cross-licensed producers or distributors⁴⁰ operating under the new drug application.

“(B) EXCEPTION.—Subparagraph (A)(i)(II) shall not apply if the Food and Drug Administration changes by regulation the requirement that, for purposes of the publication described in subparagraph (A)(i)(I), in order for drug products to be rated as therapeutically equivalent, they must be pharmaceutically equivalent and bioequivalent, as defined in subparagraph (C).

“(C) DEFINITIONS.—For purposes of this paragraph—

“(i) drug products are pharmaceutically⁴¹ equivalent if the products contain identical amounts of the same active drug ingredient in the same dosage form and meet compendial or other applicable standards of strength, quality, purity, and identity;

“(ii) drugs are bioequivalent if they do not present a known or potential bioequivalence problem, or, if they do present such a problem, they are shown to meet an appropriate standard of bioequivalence; and

⁴⁰ So in original. Probably should be “distributors”.

⁴¹ So in original. Probably should be “pharmaceutically”.

“(iii) a drug product is considered to be sold or marketed in a State if it appears in a published national listing of average wholesale prices selected by the Secretary, provided that the listed product is generally available to the public through retail pharmacies in that State.

“(8) STATE AGENCY.—The term ‘State agency’ means the agency designated under section 1902(a)(5) to administer or supervise the administration of the State plan for medical assistance.”.

(b) FUNDING.—

(1) DRUG USE REVIEW PROGRAMS.—Section 1903(a)(3) (42 U.S.C. 1936b(a)(3)) is amended—

42 USC 1396b.

(A) by striking “plus” at the end of subparagraph (C) and inserting “and”, and

(B) by adding at the end the following new subparagraph:

“(D) 75 percent of so much of the sums expended by the State plan during a quarter in 1991, 1992, or 1993, as the Secretary determines is attributable to the statewide adoption of a drug use review program which conforms to the requirements of section 1927(g); plus”.

(2) TEMPORARY INCREASE IN FEDERAL MATCH FOR ADMINISTRATIVE COSTS.—The per centum to be applied under section 1903(a)(7) of the Social Security Act for amounts expended during calendar quarters in fiscal year 1991 which are attributable to administrative activities necessary to carry out section 1927 (other than subsection (g)) of such Act shall be 75 percent, rather than 50 percent; after fiscal year 1991, the match shall revert back to 50 percent.

42 USC 1396b
note.

(c) DEMONSTRATION PROJECTS.—

42 USC 1396r-8
note.

(1) PROSPECTIVE DRUG UTILIZATION REVIEW.—

(A) The Secretary of Health and Human Services shall provide, through competitive procurement by not later than January 1, 1992, for the establishment of at least 10 statewide demonstration projects to evaluate the efficiency and cost-effectiveness of prospective drug utilization review (as a component of on-line, real-time electronic point-of-sales claims management) in fulfilling patient counseling and in reducing costs for prescription drugs.

(B) Each of such projects shall establish a central electronic repository for capturing, storing, and updating prospective drug utilization review data and for providing access to such data by participating pharmacists (and other authorized participants).

(C) Under each project, the pharmacist or other authorized participant shall assess the active drug regimens of recipients in terms of duplicate drug therapy, therapeutic overlap, allergy and cross-sensitivity reactions, drug interactions, age precautions, drug regiment compliance, prescribing limits, and other appropriate elements.

(D) Not later than January 1, 1994, the Secretary shall submit to Congress a report on the demonstration projects conducted under this paragraph.

(2) DEMONSTRATION PROJECT ON COST-EFFECTIVENESS OF REIMBURSEMENT FOR PHARMACISTS’ COGNITIVE SERVICES.—

(A) The Secretary of Health and Human Services shall conduct a demonstration project to evaluate the impact on

quality of care and cost-effectiveness of paying pharmacists under title XIX of the Social Security Act, whether or not a drug is dispensed, for drug use review services. For this purpose, the Secretary shall provide for no fewer than 5 demonstration sites in different States and the participation of a significant number of pharmacists.

(B) Not later than January 1, 1995, the Secretary shall submit a report to the Congress on the results of the demonstration project conducted under subparagraph (A).

42 USC 1396r-8
note.

(d) STUDIES.—

(1) STUDY OF DRUG PURCHASING AND BILLING ACTIVITIES OF VARIOUS HEALTH CARE SYSTEMS.—

(A) The Comptroller General shall conduct a study of the drug purchasing and billing practices of hospitals, other institutional facilities, and managed care plans which provide covered outpatient drugs in the medicaid program. The study shall compare the ingredient costs of drugs for medicaid prescriptions to these facilities and plans and the charges billed to medical assistance programs by these facilities and plans compared to retail pharmacies.

(B) The study conducted under this subsection shall include an assessment of—

(i) the prices paid by these institutions for covered outpatient drugs compared to prices that would be paid under this section,

(ii) the quality of outpatient drug use review provided by these institutions as compared to drug use review required under this section, and

(iii) the efficiency of mechanisms used by these institutions for billing and receiving payment for covered outpatient drugs dispensed under this title.

(C) By not later than May 1, 1991, the Comptroller General shall report to the Secretary of Health and Human Services (hereafter in this section referred to as the “Secretary”), the Committee on Finance of the Senate, the Committee on Energy and Commerce of the House of Representatives, and the Committees on Aging of the Senate and the House of Representatives on the study conducted under subparagraph (A).

(2) REPORT ON DRUG PRICING.—By not later than May 1 of each year, the Comptroller General shall submit to the Secretary, the Committee on Finance of the Senate, the Committee on Energy and Commerce of the House of Representatives, and the Committees on Aging of the Senate and House of Representatives an annual report on changes in prices charged by manufacturers for prescription drugs to the Department of Veterans Affairs, other Federal programs, retail and hospital pharmacies, and other purchasing groups and managed care plans.

(3) STUDY ON PRIOR APPROVAL PROCEDURES.—

(A) The Secretary, acting in consultation with the Comptroller General, shall study prior approval procedures utilized by State medical assistance programs conducted under title XIX of the Social Security Act, including—

(i) the appeals provisions under such programs; and

(ii) the effects of such procedures on beneficiary and provider access to medications covered under such programs.

(B) By not later than December 31, 1991, the Secretary and the Comptroller General shall report to the Committee on Finance of the Senate, the Committee on Energy and Commerce of the House of Representatives, and the Committees on Aging of the Senate and the House of Representatives on the results of the study conducted under subparagraph (A) and shall make recommendations with respect to which procedures are appropriate or inappropriate to be utilized by State plans for medical assistance.

(4) **STUDY ON REIMBURSEMENT RATES TO PHARMACISTS.**—

(A) The Secretary shall conduct a study on (i) the adequacy of current reimbursement rates to pharmacists under each State medical assistance programs conducted under title XIX of the Social Security Act; and (ii) the extent to which reimbursement rates under such programs have an effect on beneficiary access to medications covered and pharmacy services under such programs.

(B) By not later than December 31, 1991, the Secretary shall report to the Committee on Finance of the Senate, the Committee on Energy and Commerce of the House of Representatives, and the Committees on Aging of the Senate and the House of Representatives on the results of the study conducted under subparagraph (A).

(5) **STUDY OF PAYMENTS FOR VACCINES.**—The Secretary of Health and Human Services shall undertake a study of the relationship between State medical assistance plans and Federal and State acquisition and reimbursement policies for vaccines and the accessibility of vaccinations and immunization to children provided under this title. The Secretary shall report to the Congress on the Study not later than one year after the date of the enactment of this Act.

(6) **STUDY ON APPLICATION OF DISCOUNTING OF DRUGS UNDER MEDICARE.**—The Comptroller General shall conduct a study examining methods to encourage providers of items and services under title XVIII of the Social Security Act to negotiate discounts with suppliers of prescription drugs to such providers. The Comptroller General shall submit to Congress a report on such study no later than 1 year after the date of enactment of this subsection.

SEC. 4402. REQUIRING MEDICAID PAYMENT OF PREMIUMS AND COST-SHARING FOR ENROLLMENT UNDER GROUP HEALTH PLANS WHERE COST-EFFECTIVE.

(a) **IN GENERAL.**—Title XIX (42 U.S.C. 1396 et seq.) is amended—

(1) in section 1902(a)(25) (42 U.S.C. 1396a(a)(25))—

(A) by striking “and” at the end of subparagraph (E),

(B) by adding “and” at the end of subparagraph (F), and

(C) by adding at the end the following new subparagraph:

“(G) that the State plan shall meet the requirements of section 1906 (relating to enrollment of individuals under group health plans in certain cases);” and

(2) by inserting after section 1905 the following new section:

“**ENROLLMENT OF INDIVIDUALS UNDER GROUP HEALTH PLANS**

“**SEC. 1906.** (a) For purposes of section 1902(a)(25)(G) and subject to subsection (d), each State plan— 42 USC 1396e.

“(1) shall implement guidelines established by the Secretary, consistent with subsection (b), to identify those cases in which enrollment of an individual otherwise entitled to medical assistance under this title in a group health plan (in which the individual is otherwise eligible to be enrolled) is cost-effective (as defined in subsection (e)(2));

“(2) shall require, in case of an individual so identified and as a condition of the individual being or remaining eligible for medical assistance under this title and subject to subsection (b)(2), notwithstanding any other provision of this title, that the individual (or in the case of a child, the child’s parent) apply for enrollment in the group health plan; and

“(3) in the case of such enrollment (except as provided in subsection (c)(1)(B)), shall provide for payment of all enrollee premiums for such enrollment and all deductibles, coinsurance, and other cost-sharing obligations for items and services otherwise covered under the State plan under this title (exceeding the amount otherwise permitted under section 1916), and shall treat coverage under the group health plan as a third party liability (under section 1902(a)(25)).

“(b)(1) In establishing guidelines under subsection (a)(1), the Secretary shall take into account that an individual may only be eligible to enroll in group health plans at limited times and only if other individuals (not entitled to medical assistance under the plan) are also enrolled in the plan simultaneously.

“(2) If a parent of a child fails to enroll the child in a group health plan in accordance with subsection (a)(2), such failure shall not affect the child’s eligibility for benefits under this title.

“(c)(1)(A) In the case of payments of premiums, deductibles, coinsurance, and other cost-sharing obligations under this section shall be considered, for purposes of section 1903(a), to be payments for medical assistance.

“(B) If all members of a family are not eligible for medical assistance under this title and enrollment of the members so eligible in a group health plan is not possible without also enrolling members not so eligible—

“(i) payment of premiums for enrollment of such other members shall be treated as payments for medical assistance for eligible individuals, if it would be cost-effective (taking into account payment of all such premiums), but

“(ii) payment of deductibles, coinsurance, and other cost-sharing obligations for such other members shall not be treated as payments for medical assistance for eligible individuals.

“(2) The fact that an individual is enrolled in a group health plan under this section shall not change the individual’s eligibility for benefits under the State plan, except insofar as section 1902(a)(25) provides that payment for such benefits shall first be made by such plan.

“(d)(1) In the case of any State which is providing medical assistance to its residents under a waiver granted under section 1115, the Secretary shall require the State to meet the requirements of this section in the same manner as the State would be required to meet such requirement if the State had in effect a plan approved under this title.

“(2) This section, and section 1902(a)(25)(G), shall only apply to a State that is one of the 50 States or the District of Columbia.

“(e) In this section:

“(1) The term ‘group health plan’ has the meaning given such term in section 5000(b)(1) of the Internal Revenue Code of 1986, and includes the provision of continuation coverage by such a plan pursuant to title XXII of the Public Health Service Act, section 4980B of the Internal Revenue Code of 1986, or title VI of the Employee Retirement Income Security Act of 1974.

“(2) The term ‘cost-effective’ means, as established by the Secretary, that the reduction in expenditures under this title with respect to an individual who is enrolled in a group health plan is likely to be greater than the additional expenditures for premiums and cost-sharing required under this section with respect to such enrollment.”.

(b) **TREATMENT OF ERRONEOUS EXCESS PAYMENTS FOR MEDICAL ASSISTANCE.**—Section 1903(u)(1)(C)(iv) (42 U.S.C. 1396b(u)(1)(C)(iv)) is amended by inserting before the period at the end the following: “or with respect to payments made in violation of section 1906”.

(c) **OPTIONAL MINIMUM 6-MONTH ELIGIBILITY.**—Section 1902(e) (42 U.S.C. 1396a(e)) is amended by adding at the end the following new paragraph:

“(11)(A) In the case of an individual who is enrolled with a group health plan under section 1906 and who would (but for this paragraph) lose eligibility for benefits under this title before the end of the minimum enrollment period (defined in subparagraph (B)), the State plan may provide, notwithstanding any other provision of this title, that the individual shall be deemed to continue to be eligible for such benefits until the end of such minimum period, but only with respect to such benefits provided to the individual as an enrollee of such plan.

“(B) For purposes of subparagraph (A), the term ‘minimum enrollment period’ means, with respect to an individual’s enrollment with a group health plan, a period established by the State, of not more than 6 months beginning on the date the individual’s enrollment under the plan becomes effective.”.

(d) **CONFORMING AMENDMENTS.**—

(1) Section 1902(a)(10) (42 U.S.C. 1396a(a)(10)) is amended in the matter following subparagraph (E)—

(A) by striking “and” at the end of subdivision (IX);

(B) by inserting “and” at the end of subdivision (X); and

(C) by adding at the end the following new subdivision:

“(XI) the making available of medical assistance to cover the costs of premiums, deductibles, coinsurance, and other cost-sharing obligations for certain individuals for private health coverage as described in section 1906 shall not, by reason of paragraph (10), require the making available of any such benefits or the making available of services of the same amount, duration, and scope of such private coverage to any other individuals;”.

(2) Section 1905(a) (42 U.S.C. 1396d(a)) is amended by adding at the end the following: “The payment described in the first sentence may include expenditures for medicare cost-sharing and for premiums under part B of title XVIII for individuals who are eligible for medical assistance under the plan and (A) are receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, or with respect to whom supplemental security income benefits are being paid under title XVI, or (B) with respect to whom

there is being paid a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1902(a)(10)(A), and, except in the case of individuals 65 years of age or older and disabled individuals entitled to health insurance benefits under title XVIII who are not enrolled under part B of title XVIII, other insurance premiums for medical or any other type of remedial care or the cost thereof.”.

(3) Section 1903(a)(1) (42 U.S.C. 1396b(a)(1)) is amended by striking “(including expenditures for” and all that follows through “or the cost thereof”.

42 USC 1396a
note.

(e) **EFFECTIVE DATE.**—(1) The amendments made by this section apply (except as provided under paragraph (2)) to payments under title XIX of the Social Security Act for calendar quarters beginning on or after January 1, 1991, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation authorizing or appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by subsection (a), the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet this additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

PART 2—PROTECTION OF LOW-INCOME MEDICARE BENEFICIARIES

SEC. 4501. PHASED-IN EXTENSION OF MEDICAID PAYMENTS FOR MEDICARE PREMIUMS FOR CERTAIN INDIVIDUALS WITH INCOME BELOW 120 PERCENT OF THE OFFICIAL POVERTY LINE.

(a) **1-YEAR ACCELERATION OF BUY-IN OF PREMIUMS AND COST SHARING FOR QUALIFIED MEDICARE BENEFICIARIES UP TO 100 PERCENT OF POVERTY LINE.**—Section 1905(p)(2) (42 U.S.C. 1396d(p)(2)) is further amended—

(1) in subparagraph (B)—

(A) by adding “and” at the end of clause (ii);

(B) in clause (iii), by striking “95 percent, and” and inserting “100 percent.”; and

(C) by striking clause (iv); and

(2) in subparagraph (C)—

(A) in clause (iii), by striking “90” and inserting “95”;

(B) by adding “and” at the end of clause (iii);

(C) in clause (iv), by striking “95 percent, and” and inserting “100 percent.”; and

(D) by striking clause (v).

(b) **ENTITLEMENT.**—Section 1902(a)(10)(E) (42 U.S.C. 1395b(a)(10)(E)(ii)) is amended—

42 USC 1396a.

(1) by striking “, and” at the end of clause (i) and inserting a semicolon;

(2) by adding “and” at the end of clause (ii); and

(3) by adding at the end the following new clause:

“(iii) for making medical assistance available for medicare cost sharing described in section 1905(p)(3)(A)(ii) subject to section 1905(p)(4), for individuals who would be qualified medicare beneficiaries described in section 1905(p)(1) but for the fact that their income exceeds the income level established by the State under section 1905(p)(2) but is less than 110 percent in 1993 and 1994, and 120 percent in 1995 and years thereafter of the official poverty line (referred to in such section) for a family of the size involved.”.

(c) APPLICATION IN CERTAIN STATES AND TERRITORIES.—Section 1905(p)(4) (42 U.S.C. 1396d(p)(4)) is amended—

(1) in subparagraph (B), by inserting “or 1902(a)(10)(E)(iii)” after “subparagraph (B)”, and

(2) by adding at the end the following:

“In the case of any State which is providing medical assistance to its residents under a waiver granted under section 1115, the Secretary shall require the State to meet the requirement of section 1902(a)(10)(E) in the same manner as the State would be required to meet such requirement if the State had in effect a plan approved under this title.”

(d) CONFORMING AMENDMENT.—Section 1843(h) (42 U.S.C. 1395v(h)) is amended by adding at the end the following new paragraph:

“(3) In this subsection, the term ‘qualified medicare beneficiary’ also includes an individual described in section 1902(a)(10)(E)(iii).”.

(e) DELAY IN COUNTING SOCIAL SECURITY COLA INCREASES UNTIL NEW POVERTY GUIDELINES PUBLISHED.—

(1) IN GENERAL.—Section 1905(p) is amended—

(A) in paragraph (1)(B), by inserting “, except as provided in paragraph (2)(D)” after “supplementary social security income program”, and

(B) by adding at the end of paragraph (2) the following new subparagraph:

“(D)(i) In determining under this subsection the income of an individual who is entitled to monthly insurance benefits under title II for a transition month (as defined in clause (ii)) in a year, such income shall not include any amounts attributable to an increase in the level of monthly insurance benefits payable under such title which have occurred pursuant to section 215(i) for benefits payable for months beginning with December of the previous year.

“(ii) For purposes of clause (i), the term ‘transition month’ means each month in a year through the month following the month in which the annual revision of the official poverty line, referred to in subparagraph (A), is published.”.

(2) CONFORMING AMENDMENTS.—Section 1902(m) (42 U.S.C. 1396a(m)) is amended—

(A) in paragraph (1)(B), by inserting “, except as provided in paragraph (2)(C)” after “supplemental security income program”, and

(B) by adding at the end of paragraph (2) the following new subparagraph:

“(C) The provisions of section 1905(p)(2)(D) shall apply to determinations of income under this subsection in the same manner as they apply to determinations of income under section 1905(p).”.

42 USC 1396a
note.

(f) **EFFECTIVE DATE.**—The amendments made by this section shall apply to calendar quarters beginning on or after January 1, 1991, without regard to whether or not regulations to implement such amendments are promulgated by such date; except that the amendments made by subsection (e) shall apply to determinations of income for months beginning with January 1991.

PART 3—IMPROVEMENTS IN CHILD HEALTH

SEC. 4601. MEDICAID CHILD HEALTH PROVISIONS.

(a) **PHASED-IN MANDATORY COVERAGE OF CHILDREN UP TO 100 PERCENT OF POVERTY LEVEL.**—

(1) **IN GENERAL.**—Section 1902 (42 U.S.C. 1396a) is amended—

(A) in subsection (a)(10)(A)(i)—

(i) by striking “or” at the end of subclause (V),

(ii) by striking the semicolon at the end of subclause (VI) and inserting “, or”, and

(iii) by adding at the end the following new subclause:

“(VII) who are described in subparagraph (D) of subsection (1)(1) and whose family income does not exceed the income level the State is required to establish under subsection (1)(2)(C) for such a family;”;

(B) in subsection (a)(10)(A)(ii)(IX), by striking “or clause (i)(VI)” and inserting “, clause (i)(VI), or clause (i)(VII)”;

(C) in subsection (1)—

(i) in subparagraph (C) of paragraph (1) by inserting “children” after “(C)”;

(ii) by striking subparagraph (D) of paragraph (1) and inserting the following:

“(D) children born after September 30, 1983, who have attained 6 years of age but have not attained 19 years of age,”;

(iii) by striking subparagraph (C) of paragraph (2) and inserting the following:

“(C) For purposes of paragraph (1) with respect to individuals described in subparagraph (D) of that paragraph, the State shall establish an income level which is equal to 100 percent of the income official poverty line described in subparagraph (A) applicable to a family of the size involved.”;

(iv) in paragraph (3) by inserting “, (a)(10)(A)(i)(VII),” after “(a)(10)(A)(i)(VI)”;

(v) in paragraph (4)(A), by inserting “or subsection (a)(10)(A)(i)(VII)” after “(a)(10)(A)(i)(VI)”;

(vi) in paragraph (4)(B), by striking “or (a)(10)(A)(i)(VI)” “, and inserting “(a)(10)(A)(i)(VI), or (a)(10)(A)(i)(VII)”;

(D) in subsection (r)(2)(A), by inserting “(a)(10)(A)(i)(VII),” after “(a)(10)(A)(i)(VI),”.

(2) **CONFORMING AMENDMENT TO QUALIFIED CHILDREN.**—Section 1905(n)(2) (42 U.S.C. 1396d(n)(2)) is amended by striking “age of 7 (or any age designated by the State that exceeds 7 but does not exceed 8)” and inserting “age of 19”.

(3) **ADDITIONAL CONFORMING AMENDMENTS.**—

(A) Section 1903(f)(4) of such Act (42 U.S.C. 1396b(f)(4)) is amended—

(i) by striking “1902(a)(10)(A)(i)(IV),” and inserting “1902(a)(10)(A)(i)(III), 1902(a)(10)(A)(i)(IV), 1902(a)(10)(A)(i)(V),” and

(ii) by inserting “1902(a)(10)(A)(i)(VII),” after “1902(a)(10)(A)(i)(VI),”.

(B) Subsections (a)(3)(C) and (b)(3)(C)(i) of section 1925 of such Act (42 U.S.C. 1396r-6), as amended by section 6411(i)(3) of the Omnibus Budget Reconciliation Act of 1989, are each amended by inserting “(i)(VII),” after “(i)(VI)”.

(b) **EFFECTIVE DATE.**—(1) The amendments made by this subsection apply (except as otherwise provided in this subsection) to payments under title XIX of the Social Security Act for calendar quarters beginning on or after July 1, 1991, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

42 USC 1396a
note.

(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation authorizing or appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by this subsection, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

SEC. 4602. MANDATORY USE OF OUTREACH LOCATIONS OTHER THAN WELFARE OFFICES.

(a) **IN GENERAL.**—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)), as amended by section 4401(a)(2) of this title, is amended—

(1) by striking “and” at the end of paragraph (53),

(2) by striking the period at the end of paragraph (54) and inserting “; and”, and

(3) by inserting after paragraph (54) the following new paragraph:

“(55) provide for receipt and initial processing of applications of individuals for medical assistance under subsection (a)(10)(A)(i)(IV), (a)(10)(A)(i)(VI), (a)(10)(A)(i)(VII), or (a)(10)(A)(ii)(IX)—

“(A) at locations which are other than those used for the receipt and processing of applications for aid under part A of title IV and which include facilities defined as disproportionate share hospitals under section 1923(a)(1)(A) and Federally-qualified health centers described in section 1905(1)(2)(B), and

“(B) using applications which are other than those used for applications for aid under such part.”.

(b) **EFFECTIVE DATE.**—The amendments made by subsection (a) apply to payments under title XIX of the Social Security Act for calendar ⁴² quarters beginning on or after July 1, 1991, without

42 USC 1396a
note.

⁴² So in original. Probably should be “calendar”.

regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

SEC. 4603. MANDATORY CONTINUATION OF BENEFITS THROUGHOUT PREGNANCY OR FIRST YEAR OF LIFE.

(a) **IN GENERAL.**—Section 1902(e) (42 U.S.C. 1396a(e)) is amended—

(1) in the first sentence of paragraph (4), by inserting “(or would remain if pregnant)” after “remains”; and

(2) in paragraph (6)—

(A) by striking “At the option of a State, in” and inserting “In”;

(B) by striking “the State plan may nonetheless treat the woman as being” and inserting “the woman shall be deemed to continue to be”; and

(C) by adding at the end the following new sentence: “The preceding sentence shall not apply in the case of a woman who has been provided ambulatory prenatal care pursuant to section 1920 during a presumptive eligibility period and is then, in accordance with such section, determined to be ineligible for medical assistance under the State plan.”.

(b) **EFFECTIVE DATE.**—

(1) **INFANTS.**—The amendment made by subsection (a)(1) shall apply to individuals born on or after January 1, 1991, without regard to whether or not final regulations to carry out such amendment have been promulgated by such date.

(2) **PREGNANT WOMEN.**—The amendments made by subsection (a)(2) shall apply with respect to determinations to terminate the eligibility of women, based on change of income, made on or after January 1, 1991, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

SEC. 4604. ADJUSTMENT IN PAYMENT FOR HOSPITAL SERVICES FURNISHED TO LOW-INCOME CHILDREN UNDER THE AGE OF 6 YEARS.

(a) **IN GENERAL.**—Section 1902 (42 U.S.C. 1396a) is amended by adding at the end the following new subsection:

“(s) In order to meet the requirements of subsection (a)(55), the State plan must provide that payments to hospitals under the plan for inpatient hospital services furnished to infants who have not attained the age of 1 year, and to children who have not attained the age of 6 years and who receive such services in a disproportionate share hospital described in section 1923(b)(1), shall—

“(1) if made on a prospective basis (whether per diem, per case, or otherwise) provide for an outlier adjustment in payment amounts for medically necessary inpatient hospital services involving exceptionally high costs or exceptionally long lengths of stay,

“(2) not be limited by the imposition of day limits with respect to the delivery of such services to such individuals, and

“(3) not be limited by the imposition of dollar limits (other than such limits resulting from prospective payments as adjusted pursuant to paragraph (1)) with respect to the delivery of such services to any such individual who has not attained their first birthday (or in the case of such an individual who is an inpatient on his first birthday until such individual is discharged).”.

(b) **CONFORMING AMENDMENT.**—Section 1902(a) (42 U.S.C. 1396a(a)), as amended by section 4401(a)(2), is further amended—

- (1) by striking “and” at the end of paragraph (53);
- (2) by striking the period at the end of paragraph (54) and by inserting “; and”; and
- (3) by inserting after paragraph (54) and before the end matter the following new paragraph:

“(55) provide, in accordance with subsection (s), for adjusted payments for certain inpatient hospital services.”.

(c) **PROHIBITION ON WAIVER.**—Section 1915(b) (42 U.S.C. 1396n(b)) is amended in the matter preceding paragraph (1) by inserting “(other than subsection (s))” after “Section 1902”.

(d) **EFFECTIVE DATE.**—(1) The amendments made by this subsection shall become effective with respect to payments under title XIX of the Social Security Act for calendar quarters beginning on or after July 1, 1991, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

42 USC 1396a
note.

(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation authorizing or appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by this subsection, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

SEC. 4605. PRESUMPTIVE ELIGIBILITY.

(a) **EXTENSION OF PRESUMPTIVE ELIGIBILITY PERIOD.**—Section 1920 (42 U.S.C. 1396r-1) is amended—

(1) in subsection (b)(1)(B)—

- (A) by adding “or” at the end of clause (i),
- (B) by striking clause (ii), and
- (C) by amending clause (iii) to read as follows:

“(ii) in the case of a woman who does not file an application by the last day of the month following the month during which the provider makes the determination referred to in subparagraph (A), such last day; and”; and

(2) in subsections (c)(2)(B) and (c)(3), by striking “within 14 calendar days after the date on which” and inserting “by not later than the last day of the month following the month during which”.]⁴³

(b) **FLEXIBILITY IN APPLICATION.**—Section 1920(c)(3) (42 U.S.C. 1396r-1(c)(3)) is amended by inserting before the period at the end the following: “, which application may be the application used for the receipt of medical assistance by individuals described in section 1902(l)(1)(A)”.

(c) **EFFECTIVE DATES.**—

(1) The amendments made by subsection (a) apply to payments under title XIX of the Social Security Act for calendar quarters beginning on or after July 1, 1991, without regard to

42 USC 1396r-1
note.

⁴³ So in original. Probably should be “which”. ”.

whether or not final regulations to carry out such amendments have been promulgated by such date.

(2) The amendment made by subsection (b) shall be effective as if included in the enactment of section 9407(b) of the Omnibus Budget Reconciliation Act of 1986.

SEC. 4606. ROLE IN PATERNITY DETERMINATIONS.

(a) **IN GENERAL.**—Section 1912(a)(1)(B) (42 U.S.C. 1396k(a)(1)(B)) is amended by inserting “the individual is described in section 1902(l)(1)(A) or” after “unless (in either case)”.

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall take effect on the date of the enactment of this Act.

42 USC 1396k
note.

42 USC 1396b
note.

SEC. 4607. REPORT AND TRANSITION ON ERRORS IN ELIGIBILITY DETERMINATIONS.

(a) **REPORT.**—The Secretary of Health and Human Services shall report to Congress, by not later than July 1, 1991, on error rates by States in determining eligibility of individuals described in subparagraph (A) or (B) of section 1902(l)(1) of the Social Security Act for medical assistance under plans approved under title XIX of such Act. Such report may include data for medical assistance provided before July 1, 1989.

(b) **ERROR RATE TRANSITION.**—There shall not be taken into account, for purposes of section 1903(u) of the Social Security Act, payments and expenditures for medical assistance which—

(1) are attributable to medical assistance for individuals described in subparagraph (A) or (B) of section 1902(l)(1) of such Act, and

(2) are made on or after July 1, 1989, and before the first calendar quarter that begins more than 12 months after the date of submission of the report under subsection (a).

PART 4—MISCELLANEOUS

Subpart A—Payments

SEC. 4701. STATE MEDICAID MATCHING PAYMENTS THROUGH VOLUNTARY CONTRIBUTIONS AND STATE TAXES.

(a) **EXTENSION OF PROVISION ON VOLUNTARY CONTRIBUTIONS AND PROVIDER-SPECIFIC TAXES.**—Section 8431 of the Technical and Miscellaneous Revenue Act of 1988 is amended by striking “December 31, 1990” and inserting “December 31, 1991”.

(b) **STATE TAX CONTRIBUTIONS.**—(1) Section 1902 (42 U.S.C. 1396a) as amended by section 4604, is further amended by adding at the end the following new subsection:

“(t) Except as provided in section 1903(i), nothing in this title (including sections 1903(a) and 1905(a)) shall be construed as authorizing the Secretary to deny or limit payments to a State for expenditures, for medical assistance for items or services, attributable to taxes (whether or not of general applicability) imposed with respect to the provision of such items or services.”.

(2) Section 1903(i) (42 U.S.C. 1396b(i)) is amended—

(A) by striking the period at the end of paragraph (9) and inserting “; or”; and

(B) by adding at the end the following new paragraph:

“(10) with respect to any amount expended for medical assistance for care or services furnished by a hospital, nursing facil-

ity, or intermediate care facility for the mentally retarded to reimburse the hospital or facility for the costs attributable to taxes imposed by the State solely⁴⁴ with respect to hospitals or facilities.”.

(c) **EFFECTIVE DATES.**—The amendment made by subsection (b) shall take effect on January 1, 1991.

42 USC 1396b
note.

SEC. 4702. DISPROPORTIONATE SHARE HOSPITALS: COUNTING OF INPATIENT DAYS.

(a) **CLARIFICATION OF MEDICAID DISPROPORTIONATE SHARE ADJUSTMENT CALCULATION.**—Section 1923(b)(2) (42 U.S.C. 1396r-4(b)(2)) is amended by adding at the end the following new sentence: “In this paragraph, the term ‘inpatient day’ includes each day in which an individual (including a newborn) is an inpatient in the hospital, whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere.”.

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall take effect on July 1, 1990.

42 USC 1396r-4
note.

SEC. 4703. DISPROPORTIONATE SHARE HOSPITALS: ALTERNATIVE STATE PAYMENT ADJUSTMENTS AND SYSTEMS.

(a) **ALTERNATIVE STATE PAYMENT ADJUSTMENTS.**—Section 1923(c) (42 U.S.C. 1396r-4(c)) is amended—

- (1) by striking “or” at the end of paragraph (1);
- (2) by adding “or” at the end of paragraph (2); and
- (3) by inserting after paragraph (2) the following new paragraph:

“(3) provide for a minimum specified additional payment amount (or increased percentage payment) that varies according to type of hospital under a methodology that—

“(A) applies equally to all hospitals of each type; and

“(B) results in an adjustment for each type of hospital that is reasonably related to the costs, volume, or proportion of services provided to patients eligible for medical assistance under a State plan approved under this title or to low-income patients.”.

(b) **CLARIFICATION OF SPECIAL RULE FOR STATE USING HEALTH INSURING ORGANIZATION.**—Section 1923(e)(2) (42 U.S.C. 1396r-4(e)(2)) is amended by striking “during the 3-year period”.

(c) **CONFORMING AMENDMENT.**—Section 1923(c)(2) (42 U.S.C. 1396r-4(c)(2)) is amended by inserting after “State” “or the hospital’s low-income utilization rate (as defined in paragraph (b)(3))”.

(d) **EFFECTIVE DATE.**—The amendments made by this section shall take effect as if included in the enactment of section 412(a)(2) of the Omnibus Budget Reconciliation Act of 1987.

42 USC 1396r-4
note.

SEC. 4704. FEDERALLY⁴⁵ QUALIFIED HEALTH CENTERS.

(a) **CLARIFICATION OF USE OF MEDICARE PAYMENT METHODOLOGY.**—Section 1902(a)(13)(E) (42 U.S.C. 1396a(a)(13)(E)) is amended—

(1) by striking “may prescribe” the first place it appears and inserting “prescribes”, and

(2) by striking “on such tests of reasonableness as the Secretary may prescribe in regulations under this subparagraph” and inserting “on the same methodology used under section 1833(a)(3)”.

⁴⁴ So in original. Probably should be “solely”.

⁴⁵ So in original. Probably should be “FEDERALLY”.

(b) **MINIMUM PAYMENT RATES BY HEALTH MAINTENANCE ORGANIZATIONS.**—(1) Section 1903(m)(2)(A) (42 U.S.C. 1396b(m)(2)(A)) is amended—

(A) by striking “and” at the end of clause (vii),

(B) by striking the period at the end of clause (viii) and inserting “, and”, and

(C) by adding at the end the following new clause:

“(ix) such contract provides, in the case of an entity that has entered into a contract for the provision of services of such center with a federally qualified health center, that (I) rates of prepayment from the State are adjusted to reflect fully the rates of payment specified in section 1902(a)(13)(E), and (II) at the election of such center payments made by the entity to such a center for services described in 1905(a)(2)(C) are made at the rates of payment specified in section 1902(a)(13)(E).”.

(2) Section 1903(m)(2)(B) (42 U.S.C. 1396b(m)(2)(A)) is amended by striking “(A)” and inserting “(A) except with respect to clause (ix) of subparagraph (A),”.

(3) Section 1915(b) (42 U.S.C. 1396n(b)) is amended by inserting after “section 1902” “(other than sections 1902(a)(13)(E) and 1902(a)(10)(A) insofar as it requires provision of the care and services described in section 1905(a)(2)(C))”.

(c) **CLARIFICATION IN TREATMENT OF OUTPATIENTS.**—Section 1905(l)(2) (42 U.S.C. 1396d(l)(2)) is amended—

(1) in subparagraph (A), by striking “outpatient” and inserting “patient”,

(2) in subparagraph (B), by striking “facility” and inserting “entity”, and

(3) by redesignating clause (ii) as clause (iii) and by inserting after clause (i) the following new clause:

“(ii)(I) is receiving funding from such a grant under a contract with the recipient of such a grant, and

“(II) meets the requirements to receive a grant under section 329, 330, or 340 of such Act;”.

(d) **TREATMENT OF INDIAN TRIBES.**—The first sentence of section 1905(l)(2)(B) (42 U.S.C. 1396d(l)(2)(B)) is amended—

(1) by striking the period at the end and inserting a comma, and

(2) by adding, after and below clause (ii), the following: “and includes an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act (Public Law 93-638).”.

(e) **TECHNICAL CORRECTION.**—Section 6402 of the Omnibus Budget Reconciliation Act of 1989 is amended—

(1) by striking subsection (c), and

(2) by amending subsection (d) to read as follows:

“(c) **EFFECTIVE DATE.**—The amendments made by this section (except as otherwise provided in such amendments) shall take effect on the date of the enactment of this Act.”.

(f) **EFFECTIVE DATE.**—The amendments made by this section shall be effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1989.

SEC. 4705. HOSPICE PAYMENTS.

(a) **IN GENERAL.**—Section 1905(o)(3) (42 U.S.C. 1396d(o)(3)) is amended—

42 USC 1396a,
1396d.
42 USC 1396a
note.

42 USC 1396a
note.

(1) by striking “a State which elects” and all that follows through “with respect to” the first place it appears,

(2) by striking “skilled nursing or intermediate care facility” in subparagraphs (A) and (C) and inserting “nursing facility or intermediate care facility for the mentally retarded”;

(3) by striking “the amounts allocated under the plan for room and board in the facility, in accordance with the rates established under section 1902(a)(13),” and inserting “the additional amount described in section 1902(a)(13)(D)”, and

(4) by striking the last sentence.

(b) **EFFECTIVE DATE.**—The amendments made by subsection (a) shall be effective as if included in the amendments made by section 6408(c)(1) of the Omnibus Budget Reconciliation Act of 1989. 42 USC 1396d note.

SEC. 4706. LIMITATION ON DISALLOWANCES OR DEFERRAL OF FEDERAL FINANCIAL PARTICIPATION FOR CERTAIN INPATIENT PSYCHIATRIC HOSPITAL SERVICES FOR INDIVIDUALS UNDER AGE 21. 42 USC 1396d note.

(a) **IN GENERAL.**—(1) If the Secretary of Health and Human Services makes a determination that a psychiatric facility has failed to comply with certification of need requirements for inpatient psychiatric hospital services for individuals under age 21 pursuant to section 1905(h) of the Social Security Act, and such determination has not been subject to a final judicial decision, any disallowance or deferral of Federal financial participation under such Act based on such determination shall only apply to the period of time beginning with the first day of noncompliance and ending with the date by which the psychiatric facility develops documentation (using plan of care or utilization review procedures) of the need for inpatient care with respect to such individuals.

(2) Any disallowance of Federal financial participation under title XIX of the Social Security Act relating to the failure of a psychiatric facility to comply with certification of need requirements—

(A) shall not exceed 25 percent of the amount of Federal financial participation for the period described in paragraph (1); and

(B) shall not apply to any fiscal year before the fiscal year that is 3 years before the fiscal year in which the determination of noncompliance described in paragraph (1) is made.

(b) **EFFECTIVE DATE.**—Subsection (a) shall apply to disallowance actions and deferrals of Federal financial participation with respect to services provided before the date of enactment of this Act.

SEC. 4707. TREATMENT OF INTEREST ON INDIANA DISALLOWANCE.

With respect to any disallowance of Federal financial participation under section 1903(a) of the Social Security Act for intermediate care facility services, intermediate care facility services for the mentally retarded, or skilled nursing facility services on the ground that the facilities in the State of Indiana were not certified in accordance with law during the period beginning June 1, 1982, and ending September 30, 1984, payment of such disallowance may be deferred without interest that would otherwise accrue without regard to this subsection, until every opportunity to appeal has been exhausted.

SEC. 4708. BILLING FOR SERVICES OF SUBSTITUTE PHYSICIAN.

(a) **UNDER MEDICAID.**—Section 1902(a)(32) (42 U.S.C. 1396a(a)(32))—

- (1) by striking “and” before “(B)”,
- (2) by inserting “and” at the end of subparagraph (B), and
- (3) by adding at the end the following:

“(C) in the case of services furnished (during a period that does not exceed 14 continuous days in the case of an informal reciprocal arrangement or 90 continuous days (or such longer period as the Secretary may provide) in the case of an arrangement involving per diem or other fee-for-time compensation) by, or incident to the services of, one physician to the patients of another physician who submits the claim for such services, payment shall be made to the physician submitting the claim (as if the services were furnished by, or incident to, the physician’s services), but only if the claim identifies (in a manner specified by the Secretary) the physician who furnished the services.”.

42 USC 1396a
note.

(b) **EFFECTIVE DATE.**—The amendments made by this section shall apply to services furnished on or after the date of the enactment of this Act.

Subpart B—Eligibility and Coverage

SEC. 4711. HOME AND COMMUNITY-BASED CARE AS OPTIONAL SERVICE.

(a) **PROVISION AS OPTIONAL SERVICE.**—Section 1905(a) (42 U.S.C. 1396d(a)), as amended by section 6201, is further amended—

- (1) by striking “and” at the end of paragraph (22);
- (2) by redesignating paragraph (23) as paragraph (24); and
- (3) by inserting after paragraph (22) the following new paragraph:

“(23) home and community care (to the extent allowed and as defined in section 1929) for functionally disabled elderly individuals; and”.

(b) **HOME AND COMMUNITY CARE FOR FUNCTIONALLY DISABLED ELDERLY INDIVIDUALS.**—Title XIX (42 U.S.C. 1396 et seq.) as amended by section 4402 is further amended—

- (1) by redesignating section 1929 as section 1930; and
- (2) by inserting after section 1928 the following new section:

“HOME AND COMMUNITY CARE FOR FUNCTIONALLY DISABLED ELDERLY INDIVIDUALS

42 USC 1396t.

“SEC. 1929. (a) **HOME AND COMMUNITY CARE DEFINED.**—In this title, the term ‘home and community care’ means one or more of the following services furnished to an individual who has been determined, after an assessment under subsection (c), to be a functionally disabled elderly individual, furnished in accordance with an individual community care plan (established and periodically reviewed and revised by a qualified community care case manager under subsection (d)):

- “(1) Homemaker/home health aide services.
- “(2) Chore services.
- “(3) Personal care services.
- “(4) Nursing care services provided by, or under the supervision of, a registered nurse.
- “(5) Respite care.
- “(6) Training for family members in managing the individual.
- “(7) Adult day care.

“(8) In the case of an individual with chronic mental illness, day treatment or other partial hospitalization, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility).

“(9) Such other home and community-based services (other than room and board) as the Secretary may approve.

“(b) FUNCTIONALLY DISABLED ELDERLY INDIVIDUAL DEFINED.—

“(1) IN GENERAL.—In this title, the term ‘functionally disabled elderly individual’ means an individual who—

“(A) is 65 years of age or older,

“(B) is determined to be a functionally disabled individual under subsection (c), and

“(C) subject to section 1902(f) (as applied consistent with section 1902(r)(2)), is receiving supplemental security income benefits under title XVI (or under a State plan approved under title XVI) or, at the option of the State, is described in section 1902(a)(10)(C).

“(2) TREATMENT OF CERTAIN INDIVIDUALS PREVIOUSLY COVERED UNDER A WAIVER.—(A) In the case of a State which—

“(i) at the time of its election to provide coverage for home and community care under this section has a waiver approved under section 1915(c) or 1915(d) with respect to individuals 65 years of age or older, and

“(ii) subsequently discontinues such waiver, individuals who were eligible for benefits under the waiver as of the date of its discontinuance and who would, but for income or resources, be eligible for medical assistance for home and community care under the plan shall, notwithstanding any other provision of this title, be deemed a functionally disabled elderly individual for so long as the individual would have remained eligible for medical assistance under such waiver.

“(B) In the case of a State which used a health insuring organization before January 1, 1986, and which, as of December 31, 1990, had in effect a waiver under section 1115 that provides under the State plan under this title for personal care services for functionally disabled individuals, the term ‘functionally disabled elderly individual’ may include, at the option of the State, an individual who—

“(i) is 65 years of age or older or is disabled (as determined under the supplemental security income program under title XVI);

“(ii) is determined to meet the test of functional disability applied under the waiver as of such date; and

“(iii) meets the resource requirement and income standard that apply in the State to individuals described in section 1902(a)(10)(A)(ii)(V).

“(3) USE OF PROJECTED INCOME.—In applying section 1903(f)(1) in determining the eligibility of an individual (described in section 1902(a)(10)(C)) for medical assistance for home and community care, a State may, at its option, provide for the determination of the individual’s anticipated medical expenses (to be deducted from income) over a period of up to 6 months.

“(c) DETERMINATIONS OF FUNCTIONAL DISABILITY.—

“(1) IN GENERAL.—In this section, an individual is ‘functionally disabled’ if the individual—

“(A) is unable to perform without substantial assistance from another individual at least 2 of the following 3 activities of daily living: toileting, transferring, and eating; or

“(B) has a primary or secondary diagnosis of Alzheimer’s disease and is (i) unable to perform without substantial human assistance (including verbal reminding or physical cueing) or supervision at least 2 of the following 5 activities of daily living: bathing, dressing, toileting, transferring, and eating; or (ii) cognitively impaired so as to require substantial supervision from another individual because he or she engages in inappropriate behaviors that pose serious health or safety hazards to himself or herself or others.

“(2) ASSESSMENTS OF FUNCTIONAL DISABILITY.—

“(A) REQUESTS FOR ASSESSMENTS.—If a State has elected to provide home and community care under this section, upon the request of an individual who is 65 years of age or older and who meets the requirements of subsection (b)(1)(C) (or another person on such individual’s behalf), the State shall provide for a comprehensive functional assessment under this subparagraph which—

“(i) is used to determine whether or not the individual is functionally disabled,

“(ii) is based on a uniform minimum data set specified by the Secretary under subparagraph (C)(i), and

“(iii) uses an instrument which has been specified by the State under subparagraph (B).

No fee may be charged for such an assessment.

“(B) SPECIFICATION OF ASSESSMENT INSTRUMENT.—The State shall specify the instrument to be used in the State in complying with the requirement of subparagraph (A)(iii) which instrument shall be—

“(i) one of the instruments designated under subparagraph (C)(ii); or

“(ii) an instrument which the Secretary has approved as being consistent with the minimum data set of core elements, common definitions, and utilization guidelines specified by the Secretary in subparagraph (C)(i).

“(C) SPECIFICATION OF ASSESSMENT DATA SET AND INSTRUMENTS.—The Secretary shall—

“(i) not later than July 1, 1991—

“(I) specify a minimum data set of core elements and common definitions for use in conducting the assessments required under subparagraph (A); and

“(II) establish guidelines for use of the data set; and

“(ii) by not later than July 1, 1991, designate one or more instruments which are consistent with the specification made under subparagraph (A) and which a State may specify under subparagraph (B) for use in complying with the requirements of subparagraph (A).

“(D) PERIODIC REVIEW.—Each individual who qualifies as a functionally disabled elderly individual shall have the individual’s assessment periodically reviewed and revised not less often than once every 12 months.

“(E) CONDUCT OF ASSESSMENT BY INTERDISCIPLINARY TEAMS.—An assessment under subparagraph (A) and a review under subparagraph (D) must be conducted by an

interdisciplinary team designated by the State. The Secretary shall permit a State to provide for assessments and reviews through teams under contracts—

“(i) with public organizations; or

“(ii) with nonpublic organizations which do not provide home and community care or nursing facility services and do not have a direct or indirect ownership or control interest in, or direct or indirect affiliation or relationship with, an entity that provides, community care or nursing facility services.

“(F) CONTENTS OF ASSESSMENT.—The interdisciplinary team must—

“(i) identify in each such assessment or review each individual’s functional disabilities and need for home and community care, including information about the individual’s health status, home and community environment, and informal support system; and

“(ii) based on such assessment or review, determine whether the individual is (or continues to be) functionally disabled.

The results of such an assessment or review shall be used in establishing, reviewing, and revising the individual’s ICCP under subsection (d)(1).

“(G) APPEAL PROCEDURES.—Each State which elects to provide home and community care under this section must have in effect an appeals process for individuals adversely affected by determinations under subparagraph (F).

“(d) INDIVIDUAL COMMUNITY CARE PLAN (ICCP).—

“(1) INDIVIDUAL COMMUNITY CARE PLAN DEFINED.—In this section, the terms ‘individual community care plan’ and ‘ICCP’ mean, with respect to a functionally disabled elderly individual, a written plan which—

“(A) is established, and is periodically reviewed and revised, by a qualified case manager after a face-to-face interview with the individual or primary caregiver and based upon the most recent comprehensive functional assessment of such individual conducted under subsection (c)(2);

“(B) specifies, within any amount, duration, and scope limitations imposed on home and community care provided under the State plan, the home and community care to be provided to such individual under the plan, and indicates the individual’s preferences for the types and providers of services; and

“(C) may specify other services required by such individual.

An ICCP may also designate the specific providers (qualified to provide home and community care under the State plan) which will provide the home and community care described in subparagraph (B). Nothing in this section shall be construed as authorizing an ICCP or the State to restrict the specific persons or individuals (who are competent to provide home and community care under the State plan) who will provide the home and community care described in subparagraph (B).

“(2) QUALIFIED COMMUNITY CARE CASE MANAGER DEFINED.—In this section, the term ‘qualified community care case manager’ means a nonprofit or public agency or organization which—

“(A) has experience or has been trained in establishing, and in periodically reviewing and revising, individual community care plans and in the provision of case management services to the elderly;

“(B) is responsible for (i) assuring that home and community care covered under the State plan and specified in the ICCP is being provided, (ii) visiting each individual’s home or community setting where care is being provided not less often than once every 90 days, and (iii) informing the elderly individual or primary caregiver on how to contact the case manager if service providers fail to properly provide services or other similar problems occur;

“(C) in the case of a nonpublic agency, does not provide home and community care or nursing facility services and does not have a direct or indirect ownership or control interest in, or direct or indirect affiliation or relationship with, an entity that provides, home and community care or nursing facility services;

“(D) has procedures for assuring the quality of case management services that includes a peer review process;

“(E) completes the ICCP in a timely manner and reviews and discusses new and revised ICCPs with elderly individuals or primary caregivers; and

“(F) meets such other standards, established by the Secretary, as to assure that—

“(i) such a manager is competent to perform case management functions;

“(ii) individuals whose home and community care they manage are not at risk of financial exploitation due to such a manager; and

“(iii) meets such other standards as the State may establish.

The Secretary may waive the requirement of subparagraph (C) in the case of a nonprofit agency located in a rural area.

“(3) APPEALS PROCESS.—Each State which elects to provide home and community care under this section must have in effect an appeals process for individuals who disagree with the ICCP established.

“(e) CEILING ON PAYMENT AMOUNTS AND MAINTENANCE OF EFFORT.—

“(1) CEILING ON PAYMENT AMOUNTS.—Payments may not be made under section 1903(a) to a State for home and community care provided under this section in a quarter to the extent that the medical assistance for such care in the quarter exceeds 50 percent of the product of—

“(A) the average number of individuals in the quarter receiving such care under this section;

“(B) the average per diem rate of payment which the Secretary has determined (before the beginning of the quarter) will be payable under title XVIII (without regard to coinsurance) for extended care services to be provided in the State during such quarter; and

“(C) the number of days in such quarter.

“(2) MAINTENANCE OF EFFORT.—

“(A) ANNUAL REPORTS.—As a condition for the receipt of payment under section 1903(a) with respect to medical assistance provided by a State for home and community

care (other than a waiver under section 1915(c) and other than home health care services described in section 1905(a)(7) and personal care services specified under regulations under section 1905(a)(23)), the State shall report to the Secretary, with respect to each Federal fiscal year (beginning with fiscal year 1990) and in a format developed or approved by the Secretary, the amount of funds obligated by the State with respect to the provision of home and community care to the functionally disabled elderly in that fiscal year.

“(B) REDUCTION IN PAYMENT IF FAILURE TO MAINTAIN EFFORT.—If the amount reported under subparagraph (A) by a State with respect to a fiscal year is less than the amount reported under subparagraph (A) with respect to fiscal year 1989, the Secretary shall provide for a reduction in payments to the State under section 1903(a) in an amount equal to the difference between the amounts so reported.

“(f) MINIMUM REQUIREMENTS FOR HOME AND COMMUNITY CARE.—

“(1) REQUIREMENTS.—Home and Community care provided under this section must meet such requirements for individuals’ rights and quality as are published or developed by the Secretary under subsection (k). Such requirements shall include—

“(A) the requirement that individuals providing care are competent to provide such care; and

“(B) the rights specified in paragraph (2).

“(2) SPECIFIED RIGHTS.—The rights specified in this paragraph are as follows:

“(A) The right to be fully informed in advance, orally and in writing, of the care to be provided, to be fully informed in advance of any changes in care to be provided, and (except with respect to an individual determined incompetent) to participate in planning care or changes in care.

“(B) The right to voice grievances with respect to services that are (or fail to be) furnished without discrimination or reprisal for voicing grievances, and to be told how to complain to State and local authorities.

“(C) The right to confidentiality of personal and clinical records.

“(D) The right to privacy and to have one’s property treated with respect.

“(E) The right to refuse all or part of any care and to be informed of the likely consequences of such refusal.

“(F) The right to education or training for oneself and for members of one’s family or household on the management of care.

“(G) The right to be free from physical or mental abuse, corporal punishment, and any physical or chemical restraints imposed for purposes of discipline or convenience and not included in an individual’s ICCP.

“(H) The right to be fully informed orally and in writing of the individual’s rights.

“(I) Guidelines for such minimum compensation for individuals providing such care as will assure the availability and continuity of competent individuals to provide such care for functionally disabled individuals who have functional disabilities of varying levels of severity.

“(J) Any other rights established by the Secretary.

“(g) MINIMUM REQUIREMENTS FOR SMALL COMMUNITY CARE SETTINGS.—

“(1) SMALL COMMUNITY CARE SETTINGS DEFINED.—In this section, the term ‘small community care setting’ means—

“(A) a nonresidential setting that serves more than 2 and less than 8 individuals; or

“(B) a residential setting in which more than 2 and less than 8 unrelated adults reside and in which personal services (other than merely board) are provided in conjunction with residing in the setting.

“(2) MINIMUM REQUIREMENTS.—A small community care setting in which community care is provided under this section must—

“(A) meet such requirements as are published or developed by the Secretary under subsection (k);

“(B) meet the requirements of paragraphs (1)(A), (1)(C), (1)(D), (3), and (6) of section 1919(c), to the extent applicable to such a setting;

“(C) inform each individual receiving community care under this section in the setting, orally and in writing at the time the individual first receives community care in the setting, of the individual’s legal rights with respect to such a setting and the care provided in the setting;

“(D) meet any applicable State or local requirements regarding certification or licensure;

“(E) meet any applicable State and local zoning, building, and housing codes, and State and local fire and safety regulations; and

“(F) be designed, constructed, equipped, and maintained in a manner to protect the health and safety of residents.

“(h) MINIMUM REQUIREMENTS FOR LARGE COMMUNITY CARE SETTINGS.—

“(1) LARGE COMMUNITY CARE SETTING DEFINED.—In this section, the term ‘large community care setting’ means—

“(A) a nonresidential setting in which more than 8 individuals are served; or

“(B) a residential setting in which more than 8 unrelated adults reside and in which personal services are provided in conjunction with residing in the setting in which home and community care under this section is provided.

“(2) MINIMUM REQUIREMENTS.—A large community care setting in which community care is provided under this section must—

“(A) meet such requirements as are published or developed by the Secretary under subsection (k);

“(B) meet the requirements of paragraphs (1)(A), (1)(C), (1)(D), (3), and (6) of section 1919(c), to the extent applicable to such a setting;

“(C) inform each individual receiving community care under this section in the setting, orally and in writing at the time the individual first receives home and community care in the setting, of the individual’s legal rights with respect to such a setting and the care provided in the setting; and

“(D) meet the requirements of paragraphs (2) and (3) of section 1919(d) (relating to administration and other mat-

ters) in the same manner as such requirements apply to nursing facilities under such section; except that, in applying the requirement of section 1919(d)(2) (relating to life safety code), the Secretary shall provide for the application of such life safety requirements (if any) that are appropriate to the setting.

“(3) DISCLOSURE OF OWNERSHIP AND CONTROL INTERESTS AND EXCLUSION OF REPEATED VIOLATORS.—A community care setting—

“(A) must disclose persons with an ownership or control interest (including such persons as defined in section 1124(a)(3)) in the setting; and

“(B) may not have, as a person with an ownership or control interest in the setting, any individual or person who has been excluded from participation in the program under this title or who has had such an ownership or control interest in one or more community care settings which have been found repeatedly to be substandard or to have failed to meet the requirements of paragraph (2).

“(i) SURVEY AND CERTIFICATION PROCESS.—

“(1) CERTIFICATIONS.—

“(A) RESPONSIBILITIES OF THE STATE.—Under each State plan under this title, the State shall be responsible for certifying the compliance of providers of home and community care and community care settings with the applicable requirements of subsections (f), (g) and (h). The failure of the Secretary to issue regulations to carry out this subsection shall not relieve a State of its responsibility under this subsection.

“(B) RESPONSIBILITIES OF THE SECRETARY.—The Secretary shall be responsible for certifying the compliance of State providers of home and community care, and of State community care settings in which such care is provided, with the requirements of subsections (f), (g) and (h).

“(C) FREQUENCY OF CERTIFICATIONS.—Certification of providers and settings under this subsection shall occur no less frequently than once every 12 months.

“(2) REVIEWS OF PROVIDERS.—

“(A) IN GENERAL.—The certification under this subsection with respect to a provider of home or community care must be based on a periodic review of the provider's performance in providing the care required under ICCP's in accordance with the requirements of subsection (f).

“(B) SPECIAL REVIEWS OF COMPLIANCE.—Where the Secretary has reason to question the compliance of a provider of home or community care with any of the requirements of subsection (f), the Secretary may conduct a review of the provider and, on the basis of that review, make independent and binding determinations concerning the extent to which the provider meets such requirements.

“(3) SURVEYS OF COMMUNITY CARE SETTINGS.—

“(A) IN GENERAL.—The certification under this subsection with respect to community care settings must be based on a survey. Such survey for such a setting must be conducted without prior notice to the setting. Any individual who notifies (or causes to be notified) a community care setting of the time or date on which such a survey is scheduled to

be conducted is subject to a civil money penalty of not to exceed \$2,000. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a). The Secretary shall review each State's procedures for scheduling and conducting such surveys to assure that the State has taken all reasonable steps to avoid giving notice of such a survey through the scheduling procedures and the conduct of the surveys themselves.

“(B) SURVEY PROTOCOL.—Surveys under this paragraph shall be conducted based upon a protocol which the Secretary has provided for under subsection (k).

“(C) PROHIBITION OF CONFLICT OF INTEREST IN SURVEY TEAM MEMBERSHIP.—A State and the Secretary may not use as a member of a survey team under this paragraph an individual who is serving (or has served within the previous 2 years) as a member of the staff of, or as a consultant to, the community care setting being surveyed (or the person responsible for such setting) respecting compliance with the requirements of subsection (g) or (h) or who has a personal or familial financial interest in the setting being surveyed.

“(D) VALIDATION SURVEYS OF COMMUNITY CARE SETTINGS.—The Secretary shall conduct onsite surveys of a representative sample of community care settings in each State, within 2 months of the date of surveys conducted under subparagraph (A) by the State, in a sufficient number to allow inferences about the adequacies of each State's surveys conducted under subparagraph (A). In conducting such surveys, the Secretary shall use the same survey protocols as the State is required to use under subparagraph (B). If the State has determined that an individual setting meets the requirements of subsection (g), but the Secretary determines that the setting does not meet such requirements, the Secretary's determination as to the setting's noncompliance with such requirements is binding and supersedes that of the State survey.

“(E) SPECIAL SURVEYS OF COMPLIANCE.—Where the Secretary has reason to question the compliance of a community care setting with any of the requirements of subsection (g) or (h), the Secretary may conduct a survey of the setting and, on the basis of that survey, make independent and binding determinations concerning the extent to which the setting meets such requirements.

“(4) INVESTIGATION OF COMPLAINTS AND MONITORING OF PROVIDERS AND SETTINGS.—Each State and the Secretary shall maintain procedures and adequate staff to investigate complaints of violations of applicable requirements imposed on providers of community care or on community care settings under subsections (f), (g) and (h).

“(5) INVESTIGATION OF ALLEGATIONS OF INDIVIDUAL NEGLECT AND ABUSE AND MISAPPROPRIATION OF INDIVIDUAL PROPERTY.—The State shall provide, through the agency responsible for surveys and certification of providers of home or community care and community care settings under this subsection, for a process for the receipt, review, and investigation of allegations of individual neglect and abuse (including injuries of unknown

source) by individuals providing such care or in such setting and of misappropriation of individual property by such individuals. The State shall, after notice to the individual involved and a reasonable opportunity for hearing for the individual to rebut allegations, make a finding as to the accuracy of the allegations. If the State finds that an individual has neglected or abused an individual receiving community care or misappropriated such individual's property, the State shall notify the individual against whom the finding is made. A State shall not make a finding that a person has neglected an individual receiving community care if the person demonstrates that such neglect was caused by factors beyond the control of the person. The State shall provide for public disclosure of findings under this paragraph upon request and for inclusion, in any such disclosure of such findings, of any brief statement (or of a clear and accurate summary thereof) of the individual disputing such findings.

“(6) DISCLOSURE OF RESULTS OF INSPECTIONS AND ACTIVITIES.—

“(A) PUBLIC INFORMATION.—Each State, and the Secretary, shall make available to the public—

“(i) information respecting all surveys, reviews, and certifications made under this subsection respecting providers of home or community care and community care settings, including statements of deficiencies,

“(ii) copies of cost reports (if any) of such providers and settings filed under this title,

“(iii) copies of statements of ownership under section 1124, and

“(iv) information disclosed under section 1126.

“(B) NOTICES OF SUBSTANDARD CARE.—If a State finds that—

“(i) a provider of home or community care has provided care of substandard quality with respect to an individual, the State shall make a reasonable effort to notify promptly (I) an immediate family member of each such individual and (II) individuals receiving home or community care from that provider under this title, or

“(ii) a community care setting is substandard, the State shall make a reasonable effort to notify promptly (I) individuals receiving community care in that setting, and (II) immediate family members of such individuals.

“(C) ACCESS TO FRAUD CONTROL UNITS.—Each State shall provide its State medicaid fraud and abuse control unit (established under section 1903(q)) with access to all information of the State agency responsible for surveys, reviews, and certifications under this subsection.

“(j) ENFORCEMENT PROCESS FOR PROVIDERS OF COMMUNITY CARE.—

“(1) STATE AUTHORITY.—

“(A) IN GENERAL.—If a State finds, on the basis of a review under subsection (i)(2) or otherwise, that a provider of home or community care no longer meets the requirements of this section, the State may terminate the provider's participation under the State plan and may provide in addition for a civil money penalty. Nothing in this subparagraph shall be construed as restricting the remedies

available to a State to remedy a provider's deficiencies. If the State finds that a provider meets such requirements but, as of a previous period, did not meet such requirements, the State may provide for a civil money penalty under paragraph (2)(A) for the period during which it finds that the provider was not in compliance with such requirements.

"(B) CIVIL MONEY PENALTY.—

"(i) IN GENERAL.—Each State shall establish by law (whether statute or regulation) at least the following remedy: A civil money penalty assessed and collected, with interest, for each day in which the provider is or was out of compliance with a requirement of this section. Funds collected by a State as a result of imposition of such a penalty (or as a result of the imposition by the State of a civil money penalty under subsection (i)(3)(A)) may be applied to reimbursement of individuals for personal funds lost due to a failure of home or community care providers to meet the requirements of this section. The State also shall specify criteria, as to when and how this remedy is to be applied and the amounts of any penalties. Such criteria shall be designed so as to minimize the time between the identification of violations and final imposition of the penalties and shall provide for the imposition of incrementally more severe penalties for repeated or uncorrected deficiencies.

"(ii) DEADLINE AND GUIDANCE.—Each State which elects to provide home and community care under this section must establish the civil money penalty remedy described in clause (i) applicable to all providers of community care covered under this section. The Secretary shall provide, through regulations or otherwise by not later than July 1, 1990, guidance to States in establishing such remedy; but the failure of the Secretary to provide such guidance shall not relieve a State of the responsibility for establishing such remedy.

"(2) SECRETARIAL AUTHORITY.—

"(A) FOR STATE PROVIDERS.—With respect to a State provider of home or community care, the Secretary shall have the authority and duties of a State under this subsection, except that the civil money penalty remedy described in subparagraph (C) shall be substituted for the civil money remedy described in paragraph (1)(B)(i).

"(B) OTHER PROVIDERS.—With respect to any other provider of home or community care in a State, if the Secretary finds that a provider no longer meets a requirement of this section, the Secretary may terminate the provider's participation under the State plan and may provide, in addition, for a civil money penalty under subparagraph (C). If the Secretary finds that a provider meets such requirements but, as of a previous period, did not meet such requirements, the Secretary may provide for a civil money penalty under subparagraph (C) for the period during which the Secretary finds that the provider was not in compliance with such requirements.

“(C) CIVIL MONEY PENALTY.—If the Secretary finds on the basis of a review under subsection (i)(2) or otherwise that a home or community care provider no longer meets the requirements of this section, the Secretary shall impose a civil money penalty in an amount not to exceed \$10,000 for each day of noncompliance. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a). The Secretary shall specify criteria, as to when and how this remedy is to be applied and the amounts of any penalties. Such criteria shall be designed so as to minimize the time between the identification of violations and final imposition of the penalties and shall provide for the imposition of incrementally more severe penalties for repeated or uncorrected deficiencies.

“(k) SECRETARIAL RESPONSIBILITIES.—

“(1) PUBLICATION OF INTERIM REQUIREMENTS.—

“(A) IN GENERAL.—The Secretary shall publish, by December 1, 1991, a proposed regulation that sets forth interim requirements, consistent with subparagraph (B), for the provision of home and community care and for community care settings, including—

“(i) the requirements of subsection (c)(2) (relating to comprehensive functional assessments, including the use of assessment instruments), of subsection (d)(2)(E) (relating to qualifications for qualified case managers), of subsection (f) (relating to minimum requirements for home and community care), of subsection (g) (relating to minimum requirements for small community care settings), and of subsection (h) (relating to minimum requirements for large community care settings),⁴⁶ and

“(ii) survey protocols (or use under subsection (i)(3)(A)) which relate to such requirements.

“(B) MINIMUM PROTECTIONS.—Interim requirements under subparagraph (A) and final requirements under paragraph (2) shall assure, through methods other than reliance on State licensure processes, that individuals receiving home and community care are protected from neglect, physical and sexual abuse, financial exploitation, inappropriate involuntary restraint, and the provision of health care services by unqualified personnel in community care settings.

“(2) DEVELOPMENT OF FINAL REQUIREMENTS.—The Secretary shall develop, by not later than October 1, 1992—

“(A) final requirements, consistent with paragraph (1)(B), respecting the provision of appropriate, quality home and community care and respecting community care settings under this section, and including at least the requirements referred to in paragraph (1)(A)(i), and

“(B) survey protocols and methods for evaluating and assuring the quality of community care settings.

The Secretary may, from time to time, revise such requirements, protocols, and methods.

“(3) NO DELEGATION TO STATES.—The Secretary’s authority under this subsection shall not be delegated to States.

⁴⁶ So in original. Probably should be “settings”).

“(4) NO PREVENTION OF MORE STRINGENT REQUIREMENTS BY STATES.—Nothing in this section shall be construed as preventing States from imposing requirements that are more stringent than the requirements published or developed by the Secretary under this subsection.

“(1) WAIVER OF STATEWIDENESS.—States may waive the requirement of section 1902(a)(1) (related to State wideness)⁴⁷ for a program of home and community care under this section.

“(m) LIMITATION ON AMOUNT OF EXPENDITURES AS MEDICAL ASSISTANCE.—

“(1) LIMITATION ON AMOUNT.—The amount of funds that may be expended as medical assistance to carry out the purposes of this section shall be for fiscal year 1991, \$40,000,000, for fiscal year 1992, \$70,000,000, for fiscal year 1993, \$130,000,000, for fiscal year 1994, \$160,000,000, and for fiscal year 1995, \$180,000,000.

“(2) ASSURANCE OF ENTITLEMENT TO SERVICE.—A State which receives Federal medical assistance for expenditures for home and community care under this section must provide home and community care specified under the Individual Community Care Plan under subsection (d) to individuals described in subsection (b) for the duration of the election period, without regard to the amount of funds available to the State under paragraph (1). For purposes of this paragraph, an election period is the period of 4 or more calendar quarters elected by the State, and approved by the Secretary, for the provision of home and community care under this section.

“(3) LIMITATION ON ELIGIBILITY.—The State may limit eligibility for home and community care under this section during an election period under paragraph (2) to reasonable classifications (based on age, degree of functional disability, and need for services).

“(4) ALLOCATION OF MEDICAL ASSISTANCE.—The Secretary shall establish a limitation on the amount of Federal medical assistance available to any State during the State’s election period under paragraph (2). The limitation under this paragraph shall take into account the limitation under paragraph (1) and the number of elderly individuals age 65 or over residing in such State in relation to the number of such elderly individuals in the United States during 1990. For purposes of the previous sentence, elderly individuals shall, to the maximum extent practicable, be low-income elderly individuals.”

(c) PAYMENT FOR HOME AND COMMUNITY CARE.—

(1) REASONABLE AND ADEQUATE PAYMENT RATES.—Section 1902 (42 U.S.C. 1396a) is amended—

(A) in subsection (a)(13)—

(i) by striking “and” at the end of subparagraph (D),
(ii) by inserting “and” at the end of subparagraph (E),
and

(iii) by adding at the end the following new subparagraph:

“(F) for payment for home and community care (as defined in section 1929(a) and provided under such section) through rates which are reasonable and adequate to meet the costs of providing care, efficiently and economically, in conformity with applicable State and Federal laws, regulations, and quality and safety standards;” and

⁴⁷ So in original. Probably should be “Statewideness”).

(B) in subsection (h), by adding before the period at the end the following: “or to limit the amount of payment that may be made under a plan under this title for home and community care”.

(2) DENIAL OF PAYMENT FOR CIVIL MONEY PENALTIES, ETC.—Section 1903(i)(8) of such Act (42 U.S.C. 1396b(i)(8)) is amended by inserting “(A)” after “medical assistance” and by inserting before the semicolon at the end the following: “or (B) for home and community care to reimburse (or otherwise compensate) a provider of such care for payment of a civil money penalty imposed under this title or title XI or for legal expenses in defense of an exclusion or civil money penalty under this title or title XI if there is no reasonable legal ground for the provider’s case”

(d) CONFORMING AMENDMENTS.—

(1) Section 1902(j) (42 U.S.C. 1396a(j)) is amended by striking “(21)” and inserting “(22)”.

(2) Section 1902(a)(10)(C)(iv) (42 U.S.C. 1396a(a)(10)(C)(iv)) is amended by striking “through (20)” and inserting “through (21)”.

(e) EFFECTIVE DATES.—

(1) Except as provided in this subsection, the amendments made by this section shall apply to home and community care furnished on or after July 1, 1991, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

(2)(A) The amendments made by subsection (c)(1) shall apply to home and community care furnished on or after July 1, 1991, or, if later, 30 days after the date of publication of interim regulations under section 1929(k)(1).

(B) The amendment made by subsection (c)(2) shall apply to civil money penalties imposed after the date of the enactment of this Act.

42 USC 1396a
note.

(f) WAIVER OF PAPERWORK REDUCTION, ETC.—Chapter 35 of title 44, United States Code, and Executive Order 12291 shall not apply to information and regulations required for purposes of carrying out this Act and implementing the amendments made by this Act.

44 USC 3501
note.

SEC. 4712. COMMUNITY SUPPORTED LIVING ARRANGEMENTS SERVICES.

(a) PROVISION AS OPTIONAL SERVICE.—Section 1905(a) (42 U.S.C. 1396d(a)) as amended by section 4711 is further amended—

(1) by striking “and” at the end of paragraph (23);

(2) by redesignating paragraph (24) as paragraph (25); and

(3) by inserting after paragraph (23) the following new paragraph:

“(24) community supported living arrangements services (to the extent allowed and as defined in section 1930).”.

(b) COMMUNITY SUPPORTED LIVING ARRANGEMENTS.—Title XIX (42 U.S.C. 1396 et seq.) as amended by sections 4402 and 4711 is further amended—

(1) by redesignating section 1930 as section 1931; and

(2) by inserting after section 1929 the following new section:

“COMMUNITY SUPPORTED LIVING ARRANGEMENTS SERVICES

“SEC. 1930. (a) COMMUNITY SUPPORTED LIVING ARRANGEMENTS SERVICES.—In this title, the term ‘community supported living

42 USC 1396u.

arrangements services' means one or more of the following services meeting the requirements of subsection (h) provided in a State eligible to provide services under this section (as defined in subsection (d)) to assist a developmentally disabled individual (as defined in subsection (b)) in activities of daily living necessary to permit such individual to live in the individual's own home, apartment, family home, or rental unit furnished in a community supported living arrangement setting:

"(1) Personal assistance.

"(2) Training and habilitation services (necessary to assist the individual in achieving increased integration, independence and productivity).

"(3) 24-hour emergency assistance (as defined by the Secretary).

"(4) Assistive technology.

"(5) Adaptive equipment.

"(6) Other services (as approved by the Secretary, except those services described in subsection (g)).

"(7) Support services necessary to aid an individual to participate in community activities.

"(b) **DEVELOPMENTALLY DISABLED INDIVIDUAL DEFINED.**—In this title the term, 'developmentally disabled individual' means an individual who as defined by the Secretary is described within the term 'mental retardation and related conditions' as defined in regulations as in effect on July 1, 1990, and who is residing with the individual's family or legal guardian in such individual's own home in which no more than 3 other recipients of services under this section are residing and without regard to whether or not such individual is at risk of institutionalization (as defined by the Secretary).

"(c) **CRITERIA FOR SELECTION OF PARTICIPATING STATES.**—The Secretary shall develop criteria to review the applications of States submitted under this section to provide community supported living arrangement services. The Secretary shall provide in such criteria that during the first 5 years of the provision of services under this section that no less than 2 and no more than 8 States shall be allowed to receive Federal financial participation for providing the services described in this section.

"(d) **QUALITY ASSURANCE.**—A State selected by the Secretary to provide services under this section shall in order to continue to receive Federal financial participation for providing services under this section be required to establish and maintain a quality assurance program, that provides that—

"(1) the State will certify and survey providers of services under this section (such surveys to be unannounced and average at least 1 a year);

"(2) the State will adopt standards for survey and certification that include—

"(A) minimum qualifications and training requirements for provider staff;

"(B) financial operating standards; and

"(C) a consumer grievance process;

"(3) the State will provide a system that allows for monitoring boards consisting of providers, family members, consumers, and neighbors;

"(4) the State will establish reporting procedures to make available information to the public;

“(5) the State will provide ongoing monitoring of the health and well-being of each recipient;

“(6) the State will provide the services defined in subsection (a) in accordance with an individual support plan (as defined by the Secretary in regulations); and

“(7) the State plan amendment under this section shall be reviewed by the State Planning Council established under section 124 of the Developmental Disabilities Assistance and Bill of Rights Act, and the Protection and Advocacy System established under section 142 of such Act.”.⁴⁸

The Secretary shall not approve a quality assurance plan under this subsection and allow a State to continue to receive Federal financial participation under this section unless the State provides for public hearings on the plan prior to adoption and implementation of its plan under this subsection.

“(e) MAINTENANCE OF EFFORT.—States selected by the Secretary to receive Federal financial participation to provide services under this section shall maintain current levels of spending for such services in order to be eligible to continue to receive Federal financial participation for the provision of such services under this section.

“(f) EXCLUDED SERVICES.—No Federal financial participation shall be allowed for the provision of the following services under this section:

“(1) Room and board.

“(2) Cost of prevocational, vocational and supported employment.

“(g) WAIVER OF REQUIREMENTS.—The Secretary may waive such provisions of this title as necessary to carry out the provisions of this section including the following requirements of this title—

“(1) comparability of amount, duration, and scope of services; and

“(2) statewideness.

“(h) MINIMUM PROTECTIONS.—

“(1) PUBLICATION OF INTERIM AND FINAL REQUIREMENTS.—

“(A) IN GENERAL.—The Secretary shall publish, by July 1, 1991, a regulation (that shall be effective on an interim basis pending the promulgation of final regulations), and by October 1, 1992, a final regulation, that sets forth interim and final requirements, respectively, consistent with subparagraph (B), to protect the health, safety, and welfare of individuals receiving community supported living arrangements services.

“(B) MINIMUM PROTECTIONS.—Interim and final requirements under subparagraph (A) shall assure, through methods other than reliance on State licensure processes or the State quality assurance programs under subsection (d), that—

“(i) individuals receiving community supported living arrangements services are protected from neglect, physical and sexual abuse, and financial exploitation;

“(ii) a provider of community supported living arrangements services may not use individuals who have been convicted of child or client abuse, neglect, or mistreatment or of a felony involving physical harm to an individual and shall take all reasonable steps to determine whether applicants for employment by the provider have histories indicating involvement in child

⁴⁸ So in original. Probably should be “Act.”.

or client abuse, neglect, or mistreatment or a criminal record involving physical harm to an individual;

“(iii) individuals or entities delivering such services are not unjustly enriched as a result of abusive financial arrangements (such as owner lease-backs); and

“(iv) individuals or entities delivering such services to clients, or relatives of such individuals, are prohibited from being named beneficiaries of life insurance policies purchased by (or on behalf of) such clients.

“(2) SPECIFIED REMEDIES.—If the Secretary finds that a provider has not met an applicable requirement under subsection (h), the Secretary shall impose a civil money penalty in an amount not to exceed \$10,000 for each day of noncompliance. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

“(i) TREATMENT OF FUNDS.—Any funds expended under this section for medical assistance shall be in addition to funds expended for any existing services covered under the State plan, including any waiver services for which an individual receiving services under this program is already eligible.

“(j) LIMITATION ON AMOUNTS OF EXPENDITURES AS MEDICAL ASSISTANCE.—The amount of funds that may be expended as medical assistance to carry out the purposes of this section shall be for fiscal year 1991, \$5,000,000, for fiscal year 1992, \$10,000,000, for fiscal year 1993, \$20,000,000, for fiscal year 1994, \$30,000,000, for fiscal year 1995, \$35,000,000, and for fiscal years thereafter such sums as provided by Congress.”.

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall apply to community supported living arrangements services furnished on or after the later of July 1, 1991, or 30 days after the publication of regulations setting forth interim requirements under subsection (h) without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

(2) APPLICATION PROCESS.—The Secretary of Health and Human Services shall provide that the applications required to be submitted by States under this section shall be received and approved prior to the effective date specified in paragraph (1).

SEC. 4713. PROVIDING FEDERAL MEDICAL ASSISTANCE FOR PAYMENTS FOR PREMIUMS FOR “COBRA” CONTINUATION COVERAGE WHERE COST EFFECTIVE.

(a) OPTIONAL PAYMENT OF COBRA PREMIUMS FOR QUALIFIED COBRA CONTINUATION BENEFICIARIES.—Section 1902 (42 U.S.C. 1396a) is amended—

(1) in subsection (a)(10)—

(A) by striking “and” at the end of subparagraph (D),

(B) by adding “and” at the end of subparagraph (E),

(C) by inserting after subparagraph (E) the following new subparagraph:

“(F) at the option of a State, for making medical assistance available for COBRA premiums (as defined in subsection (u)(2)) for qualified COBRA continuation beneficiaries described in section 1902(u)(1);”, and

(D) in the matter following subparagraph (E), by striking “and” before “(X)” and by inserting before the semicolon at the end the following: “, and (XI) the medical assistance made available to an individual described in subsection (u)(1) who is eligible for medical assistance only because of subparagraph (F) shall be limited to medical assistance for COBRA continuation premiums (as defined in subsection (u)(2))”; and

(2) by adding after the subsections added by section 4604 and 4701(b) the following new subsection:

“(u)(1) Individuals described in this paragraph are individuals—

“(A) who are entitled to elect COBRA continuation coverage (as defined in paragraph (3)),

“(B) whose income (as determined under section 1612 for purposes of the supplemental security income program) does not exceed 100 percent of the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved,

“(C) whose resources (as determined under section 1613 for purposes of the supplemental security income program) do not exceed twice the maximum amount of resources that an individual may have and obtain benefits under that program, and

“(D) with respect to whose enrollment for COBRA continuation coverage the State has determined that the savings in expenditures under this title resulting from such enrollment is likely to exceed the amount of payments for COBRA premiums made.

“(2) For purposes of subsection (a)(10)(F) and this subsection, the term ‘COBRA premiums’ means the applicable premium imposed with respect to COBRA continuation coverage.

“(3) In this subsection, the term ‘COBRA continuation coverage’ means coverage under a group health plan provided by an employer with 75 or more employees provided pursuant to title XXII of the Public Health Service Act, section 4980B of the Internal Revenue Code of 1986, or title VI of the Employee Retirement Income Security Act of 1974.

“(4) Notwithstanding subsection (a)(17), for individuals described in paragraph (1) who are covered under the State plan by virtue of subsection (a)(10)(A)(ii)(XI)—

“(A) the income standard to be applied is the income standard described in paragraph (1)(B), and

“(B) except as provided in section 1612(b)(4)(B)(ii), costs incurred for medical care or for any other type of remedial care shall not be taken into account in determining income.

Any different treatment provided under this paragraph for such individuals shall not, because of subsection (a)(10)(B) or (a)(17), require or permit such treatment for other individuals.”.

(b) CONFORMING AMENDMENT.—Section 1905(a) (42 U.S.C. 1396d(a)) is amended—

(1) by striking “or” at the end of clause (viii),

(2) by adding “or” at the end of clause (ix), and

(3) by inserting after clause (ix) the following new clause:

“(x) individuals described in section 1902(u)(1).”.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to medical assistance furnished on or after January 1, 1991.

42 USC 1396a
note.

SEC. 4714. PROVISIONS RELATING TO SPOUSAL IMPOVERISHMENT.

- 42 USC 1396r-5. (a) **CLARIFICATION OF NON-APPLICATION OF STATE COMMUNITY PROPERTY LAWS.**—Section 1924(b)(2) (42 U.S.C. 1396r-1(b)(2)) as amended by subsection (a), is further amended by striking “, after the institutionalized spouse has been determined or redetermined to be eligible for medical assistance” and inserting “for purposes of the post-eligibility income determination described in subsection (d)”.
- (b) **CLARIFICATION OF TRANSFER OF RESOURCES TO COMMUNITY SPOUSE.**—Section 1924(f)(1) (42 U.S.C. 1396r-5(f)(1)) is amended by striking “section 1917” and inserting “section 1917(c)(1)”.
- 42 USC 1396r-5. (c) **CLARIFICATION OF PERIOD OF CONTINUOUS ELIGIBILITY.**—Section 1924(c)(1) (42 U.S.C. 1396r-1(c)(1)) is amended by striking “the beginning of a continuous period of institutionalization of the institutionalized spouse” each place it appears and inserting “the beginning of the first continuous period of institutionalization (beginning on or after September 30, 1989) of the institutionalized spouse”.
- 42 USC 1396r-5 note. (d) **EFFECTIVE DATE.**—The amendments made this section shall take effect as if included in the enactment of section 303 of the Medicare Catastrophic Coverage Act of 1988.

SEC. 4715. DISREGARDING GERMAN REPARATION PAYMENTS FROM POST-ELIGIBILITY TREATMENT OF INCOME UNDER THE MEDICAID PROGRAM.

- (a) **IN GENERAL.**—Section 1902(r)(1) (42 U.S.C. 1396a(r)(1)) is amended by inserting “there shall be disregarded reparation payments made by the Federal Republic of Germany and” after “under such a waiver”.
- 42 USC 1396a note. (b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall apply to treatment of income for months beginning more than 30 days after the date of the enactment of this Act.

SEC. 4716. AMENDMENTS RELATING TO MEDICAID TRANSITION PROVISION.

- 42 USC 1396r-6. (a) **AMENDMENTS.**—Subsection (f) of section 1925 (42 U.S.C. 1396s) is amended—
- (1) in subsection (b)(2)(B)(i), by inserting at the end the following: “A State may permit such additional extended assistance under this subsection notwithstanding a failure to report under this clause if the family has established, to the satisfaction of the State, good cause for the failure to report on a timely basis.”;
- (2) in subsection (b)(2)(B), by adding at the end the following new clause:
- “(iii) **CLARIFICATION ON FREQUENCY OF REPORTING.**—A State may not require that a family receiving extended assistance under this subsection or subsection (a) report more frequently than as required under clause (i) or (ii).”; and
- (3) in subsection (b)(3)(B), by adding at the end the following: “No such termination shall be effective earlier than 10 days after the date of mailing of such notice.”.
- 42 USC 1396r-6 note. (b) **EFFECTIVE DATE.**—The amendments made by subsection (a) shall be effective as if included in the enactment of the Family Support Act of 1988.

SEC. 4717. CLARIFYING EFFECT OF HOSPICE ELECTION.

Section 1905(o)(1)(A) (42 U.S.C. 1396d(o)(1)(A)) is amended by inserting “and for which payment may otherwise be made under title XVIII” after “described in section 1812(d)(2)(A)”.

SEC. 4718. MEDICALLY NEEDY INCOME LEVELS FOR CERTAIN 1-MEMBER FAMILIES.

42 USC 1396b
note.

(a) **IN GENERAL.**—For purposes of section 1903(f)(1)(B), for payments made before, on, or after the date of the enactment of this Act, a State described in subparagraph (B) may use, in determining the “highest amount which would ordinarily be paid to a family of the same size” (under the State’s plan approved under part A of title IV of such Act) in the case of a family consisting only of one individual and without regard to whether or not such plan provides for aid to families consisting only of one individual, an amount reasonably related to the highest money payment which would ordinarily be made under such a plan to a family of two without income or resources.

(b) **STATES COVERED.**—Subsection (a) shall only apply to a State the State plan of which (under title XIX of the Social Security Act) as of June 1, 1989, provided for the policy described in such paragraph. For purposes of the previous sentence, a State plan includes all the matter included in a State plan under section 2373(c)(5) of the Deficit Reduction Act of 1984 (as amended by section 9 of the Medicare and Medicaid Patient and Program Protection Act of 1987).

SEC. 4719. CODIFICATION OF COVERAGE OF REHABILITATION SERVICES.

(a) **IN GENERAL.**—Section 1905(a)(13) (42 U.S.C. 1396d(a)(13)) is amended by inserting before the semicolon at the end the following: “, including any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level”.

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall take effect on the date of the enactment of this Act.

SEC. 4720. PERSONAL CARE SERVICES FOR MINNESOTA.

(a) **CLARIFICATION OF COVERAGE.**—In applying section 1905 of the Social Security Act with respect to Minnesota, medical assistance shall include payment for personal care services described in subsection (b).

(b) **PERSONAL CARE SERVICES DEFINED.**—For purposes of this section, the term “personal care services” means services—

42 USC 1396d
note.

(1) prescribed by a physician for an individual in accordance with a plan of treatment,

(2) provided by a person who is qualified to provide such services who is not a member of the individual’s family,

(3) supervised by a registered nurse, and

(4) furnished in a home or other location;

but does not include such services furnished to an inpatient or resident of a hospital or nursing facility.

(c) **EFFECTIVE DATE.**—This section shall take effect on the date of the enactment of this Act and shall apply with respect to—

- (1) personal care services furnished before such date pursuant to regulations in effect as of July 1, 1989; and
- (2) such services furnished before October 1, 1994.

SEC. 4721. MEDICAID COVERAGE OF PERSONAL CARE SERVICES OUTSIDE THE HOME.

(a) **IN GENERAL.**—Section 1905(a)(7) (42 U.S.C. 1396d(a)(7)) is amended by striking “services” and inserting “services including personal care services (A) prescribed by a physician for an individual in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual’s family, (C) supervised by a registered nurse, and (D) furnished in a home or other location; but not including such services furnished to an inpatient or resident of a nursing facility”.

42 USC 1396d
note.

(b) **EFFECTIVE DATE.**—The amendment made by this section shall become effective with respect to personal care services provided on or after October 1, 1994.

SEC. 4722. MEDICAID COVERAGE OF ALCOHOLISM AND DRUG DEPENDENCY TREATMENT SERVICES.

Section 1905(a) of the Social Security Act is amended by adding at the end the following new sentence: “No service (including counseling) shall be excluded from the definition of ‘medical assistance’ solely because it is provided as a treatment service for alcoholism or drug dependency.”

SEC. 4723. MEDICAID SPENDDOWN OPTION.

(a) **IN GENERAL.**—Section 1903(f)(2) (42 U.S.C. 1396b(f)(2)) is amended by—

- (1) inserting “(A)” after “(2)”; and
- (2) by adding before the period at the end the following: “or, (B) notwithstanding section 1916 at State option, an amount paid by such family, at the family’s option, to the State, provided that the amount, when combined with costs incurred in prior months, is sufficient when excluded from the family’s income to reduce such family’s income below the applicable income limitation described in paragraph (1). The amount of State expenditures for which medical assistance is available under subsection (a)(1) will be reduced by amounts paid to the State pursuant to this subparagraph.”

(b) **CONFORMING AMENDMENT.**—Section 1902(a)(17) (42 U.S.C. 1396a(a)(17)) is amended by inserting after “insurance premiums” “, payments made to the State under section 1903(f)(2)(B),”.

SEC. 4724. OPTIONAL STATE MEDICAID DISABILITY DETERMINATIONS INDEPENDENT OF THE SOCIAL SECURITY ADMINISTRATION.

(a) **IN GENERAL.**—Section 1902 (42 U.S.C. 1396a) as amended by this title, is further amended by adding at the end the following new subsection:

“(v)(1) A State plan may provide for the making of determinations of disability or blindness for the purpose of determining eligibility for medical assistance under the State plan by the single State agency or its designee, and make medical assistance available to individuals whom it finds to be blind or disabled and who are determined otherwise eligible for such assistance during the period of time prior to which a final determination of disability or blind-

ness is made by the Social Security Administration with respect to such an individual. In making such determinations, the State must apply the definitions of disability and blindness found in section 1614(a) of the Social Security Act.”.

Subpart C—Health Maintenance Organizations

SEC. 4731. REGULATION OF INCENTIVE PAYMENTS TO PHYSICIANS.

(a) **PHYSICIAN PAYMENT PLAN.**—Section 1903(m)(2)(A) (42 U.S.C. 1396b(m)(2)(A)) as amended by this title is further amended—

(1) by striking “, and” at the end of clause (viii) and inserting a semicolon;

(2) by striking the period at the end of clause (ix) and inserting “; and”; and

(3) by adding at the end the following new clause:

“(x) any physician incentive plan that it operates meets the requirements described in section 1876(i)(8).”.

(b) **REPEAL OF PROHIBITION AGAINST PHYSICIAN INCENTIVE PAYMENTS.**—Section 1128A(b)(1) (42 U.S.C. 1320a-7a(b)(1)) is—

(1) **REPEAL OF PROHIBITION.**—Section 1128A(b)(1) (42 U.S.C. 1320a-7a(b)(1)) is amended by striking “or an entity with a contract under section 1903(m)”.

(2) **PENALTIES.**—Section 1903(m)(5)(A) (42 U.S.C. 1396b(m)(5)(A)) is amended—

(A) by striking “or” at the end of clause (iii);

(B) by adding “or” at the end of clause (iv); and

(C) by adding at the end the following new clause:

“(v) fails to comply with the requirements of section 1876(i)(8).”.

(c) **EFFECTIVE DATE.**—The amendments made by subsections (a) and (b)(2) shall apply with respect to contract years beginning on or after January 1, 1992, and the amendments made by subsection (b)(1) shall take effect on the date of the enactment of this Act.

42 USC 1396b
note.

SEC. 4732. SPECIAL RULES.

(a) **WAIVER OF 75 PERCENT RULE FOR PUBLIC ENTITIES.**—Section 1903(m)(2)(D) (42 U.S.C. 1396b(m)(2)(D)) is amended by striking “(i) special circumstances warrant such modification or waiver, and (ii)”.

(b) **EXTENDING SPECIAL TREATMENT TO MEDICARE COMPETITIVE MEDICAL PLANS.**—

(1) **6-MONTH MINIMUM ENROLLMENT PERIOD OPTION.**—Section 1902(e)(2)(A) (42 U.S.C. 1396a(e)(2)(A)) is amended by inserting “or with an eligible organization with a contract under section 1876” after “1903(m)(2)(A)”.

(2) **ENROLLMENT LOCK-IN.**—Section 1903(m)(2)(F)(i) (42 U.S.C. 1396b(m)(2)(F)(i)) is amended—

(A) by striking “(G) or” and inserting “(G),”, and

(B) adding at the end the following: “or with an eligible organization with a contract under section 1876 which meets the requirement of subparagraph (A)(ii), or”.

(c) **AUTOMATIC 1-MONTH REENROLLMENT FOR SHORT PERIODS OF INELIGIBILITY.**—Section 1903(m)(2) is amended by adding at the end the following new subparagraph:

“(H) In the case of an individual who—

“(i) in a month is eligible for benefits under this title and enrolled with a health maintenance organization with a contract under this paragraph,

“(ii) in the next month (or in the next 2 months) is not eligible for such benefits, but

“(iii) in the succeeding month is again eligible for such benefits,

the State plan, subject to subparagraph (A)(vi), may enroll the individual for that succeeding month with the health maintenance organization described in clause (i) if the organization continues to have a contract under this paragraph with the State.”.

42 USC 1396b.

(d) **ELIMINATION OF PROVISIONAL QUALIFICATION FOR HMOs.**—Section 1903(m) is amended—

(1) in paragraph (2)(A)(i), by striking “(or the State as authorized by paragraph (3))”, and

(2) by striking paragraph (3).

42 USC 1396a
note.

(e) **EFFECTIVE DATE.**—The amendments made by this section shall take effect on the date of the enactment of this Act.

SEC. 4733. EXTENSION AND EXPANSION OF MINNESOTA PREPAID MEDIC-AID DEMONSTRATION PROJECT.

Section 507 of the Family Support Act of 1988 is amended—

(1) by striking “1991” and inserting “1996”; and

(2) by striking the period at the end and inserting the following: “, and shall amend such waiver to permit the State to expand such demonstration project to other counties if the amount of medical assistance provided under title XIX of such Act after such expansion will not exceed the amount of medical assistance provided under such title had the project not been expanded to other counties.”.

SEC. 4734. TREATMENT OF CERTAIN COUNTY-OPERATED HEALTH INSUR-ING ORGANIZATIONS.

42 USC 1396b
note.

Section 9517(c) of the Consolidated Omnibus Budget Reconciliation Act of 1985 is amended—

(1) in paragraph (2)(A), by inserting “and in paragraph (3)” after “subparagraph (B)”, and

(2) by adding at the end the following new paragraph:

“(3)(A) Subject to subparagraph (C), in the case of up to 3 health insuring organizations which are described in subparagraph (B), which first become operational on or after January 1, 1986, and which are designated by the Governor, and approved by the Legislature, of California, the amendments made by paragraph (1) shall not apply.

“(B) A health insuring organization described in this subparagraph is one that—

“(i) is operated directly by a public entity established by a county government in the State of California under a State enabling statute;

“(ii) enrolls all medicaid beneficiaries residing in the county in which it operates;

“(iii) meets the requirements for health maintenance organizations under the Knox-Keene Act (Cal. Health and Safety Code, section 1340 et seq.) and the Waxman-Duffy Act (Cal. Welfare and Institutions Code, section 14450 et seq.);

“(iv) assures a reasonable choice of providers, which includes providers that have historically served medicaid beneficiaries and which does not impose any restriction which substantially impairs access to covered services of adequate quality where medically necessary;

“(v) provides for a payment adjustment for a disproportionate share hospital (as defined under State law consistent with section 1923 of the Social Security Act) in a manner consistent with the requirements of such section; and

“(vi) provides for payment, in the case of childrens’ hospital services provided to medicaid beneficiaries who are under 21 years of age, who are children with special health care needs under title V of the Social Security Act, and who are receiving care coordination services under such title, at rates determined by the California Medical Assistance Commission.

“(C) Subparagraph (A) shall not apply with respect to any period for which the Secretary of Health and Human Services determines that the number of medicaid beneficiaries enrolled with health insuring organizations described in subparagraph (B) exceeds 10 percent of the number of such beneficiaries in the State of California.

“(D) In this paragraph, the term ‘medicaid beneficiary’ means an individual who is entitled to medical assistance under the State plan under title XIX of the Social Security Act, other than a qualified medicare beneficiary who is only entitled to such assistance because of section 1902(a)(10)(E) of such title.”.

Subpart D—Demonstration Projects and Home and Community-Based Waivers

SEC. 4741. HOME AND COMMUNITY-BASED WAIVERS.

(a) **TREATMENT OF ROOM AND BOARD.**—(1) Subsections (c)(1) and (d)(1) of section 1915 (42 U.S.C. 1396n) are each amended by adding at the end the following: “For purposes of this subsection, the term ‘room and board’ shall not include an amount established under a method determined by the State to reflect the portion of costs of rent and food attributable to an unrelated personal caregiver who is residing in the same household with an individual who, but for the assistance of such caregiver, would require admission to a hospital, nursing facility, or intermediate care facility for the mentally retarded.”.

(b) **ADJUSTMENT TO 1915(d) CEILING TO TAKE INTO ACCOUNT THE ADDED COSTS OF OBRA 87.**—Section 1915(d)(5)(B)(iv) (42 U.S.C. 1396n(d)(5)(B)(iv)) is amended by striking “this title” the first place it appears and inserting “this title whose provisions become effective on or after such date”.

SEC. 4742. TIMELY PAYMENT UNDER WAIVERS OF FREEDOM OF CHOICE OF HOSPITAL SERVICES.

(a) **IN GENERAL.**—Section 1915(b)(4) (42 U.S.C. 1396n(b)(4)) is amended by inserting before the period at the end the following: “and if providers under such restriction are paid on a timely basis in the same manner as health care practitioners must be paid under section 1902(a)(37)(A)”.

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall take effect as of the first calendar quarter beginning more than 30 days after the date of the enactment of this Act.

(c) **TREATMENT OF PERSONS WITH MENTAL RETARDATION OR A RELATED CONDITION IN A DECERTIFIED FACILITY.**—

(1) **IN GENERAL.**—Section 1915(c)(7) (42 U.S.C. 1396n(c)(7)) is amended by adding at the end the following new subparagraph:

42 USC 1396n
note.

“(C) In making estimates under paragraph (2)(D) in the case of a waiver to the extent that it applies to individuals with mental retardation or a related condition who are resident in an intermediate care facility for the mentally retarded the participation of which under the State plan is terminated, the State may determine the average per capita expenditures that would have been made in a fiscal year for those individuals without regard to any such termination.”.

42 USC 1396n
note.

(2) **EFFECTIVE DATE.**—The amendment made by paragraph (1) shall apply as if included in the enactment of the Omnibus Budget Reconciliation Act of 1981, but shall only apply to facilities the participation of which under a State plan under title XIX of the Social Security Act is terminated on or after the date of the enactment of this Act.

(d) **SCOPE OF RESPITE CARE.**—

42 USC 1396n.

(1) **IN GENERAL.**—Section 1915(c)(4) is amended by adding at the end the following:

“Except as provided under paragraph (2)(D), the Secretary may not restrict the number of hours or days of respite care in any period which a State may provide under a waiver under this subsection.”.

42 USC 1396n
note.

(2) **EFFECTIVE DATE.**—The amendment made by paragraph (1) shall apply as if included in the enactment of the Omnibus Budget Reconciliation Act of 1981.

42 USC 1396n
note.

(e) **PERMITTING ADJUSTMENT IN ESTIMATES TO TAKE INTO ACCOUNT PREADMISSION SCREENING REQUIREMENT.**—In the case of a waiver under section 1915(c) of the Social Security Act for individuals with mental retardation or a related condition in a State, the Secretary of Health and Human Services shall permit the State to adjust the estimate of average per capita expenditures submitted under paragraph (2)(D) of such section, with respect to such expenditures made on or after January 1, 1989, to take into account increases in expenditures for, or utilization of, intermediate care facilities for the mentally retarded resulting from implementation of section 1919(e)(7)(A) of such Act.

SEC. 4744. PROVISIONS RELATING TO FRAIL ELDERLY DEMONSTRATION PROJECT WAIVERS.

(a) **EXPANSION OF WAIVERS.**—Section 9412(b) of the Omnibus Budget Reconciliation Act of 1986 is amended—

(1) in paragraph (1), by striking “10” and inserting “15”; and

(2) by adding at the end the following new paragraph:

“(3) In the case of an organization receiving an initial waiver under this subsection on or after October 1, 1990, the Secretary (at the request of the organization) shall not require the organization to provide services under title XVIII of the Social Security Act on a capitated or other risk basis during the first 2 years of the waiver.”.

(b) **APPLICATION OF SPOUSAL IMPOVERISHMENT RULES.**—(1) Section 1924(a) (42 U.S.C. 1396r-5(a)) is amended by adding at the end the following new paragraph:

“(5) **APPLICATION TO INDIVIDUALS RECEIVING SERVICES FROM ORGANIZATIONS RECEIVING CERTAIN WAIVERS.**—This section applies to individuals receiving institutional or noninstitutional services from any organization receiving a frail elderly demonstration project waiver under section 9412(b) of the Omnibus Budget Reconciliation Act of 1986.”.

(2) Section 9412(b) of the Omnibus Budget Reconciliation Act of 1986, as amended by subsection (a), is amended by adding at the end the following new paragraph:

“(4) Section 1924 of the Social Security Act shall apply to any individual receiving services from an organization receiving a waiver under this subsection.”.

SEC. 4745. DEMONSTRATION PROJECTS TO STUDY THE EFFECT OF ALLOWING STATES TO EXTEND MEDICAID COVERAGE TO CERTAIN LOW-INCOME FAMILIES NOT OTHERWISE QUALIFIED TO RECEIVE MEDICAID BENEFITS.

42 USC 1396a
note.

(a) DEMONSTRATION PROJECTS.—

(1) **IN GENERAL.**—(A) The Secretary of Health and Human Services (hereafter in this section referred to as the “Secretary”) shall enter into agreements with 3 and no more than 4 States submitting applications under this section for the purpose of conducting demonstration projects to study the effect on access to, and costs of, health care of eliminating the categorical eligibility requirement for medicaid benefits for certain low-income individuals.

(B) In entering into agreements with States under this section the Secretary shall provide that at least 1 and no more than 2 of the projects are conducted on a substate basis.

(2) **REQUIREMENTS.**—(A) The Secretary may not enter into an agreement with a State to conduct a project unless the Secretary determines that—

(i) the project can reasonably be expected to improve access to health insurance coverage for the uninsured;

(ii) with respect to projects for which the statewideness requirement has not been waived, the State provides, under its plan under title XIX of the Social Security Act, for eligibility for medical assistance for all individuals described in subparagraphs (A), (B), (C), and (D) of paragraph (1) of section 1902(l) of such Act (based on the State’s election of certain eligibility options the highest income standards and, based on the State’s waiver of the application of any resource standard);

(iii) eligibility for benefits under the project is limited to individuals in families with income below 150 percent of the income official poverty line and who are not individuals receiving benefits under title XIX of the Social Security Act;

(iv) if the Secretary determines that it is cost-effective for the project to utilize employer coverage (as described in section 1925(b)(4)(D) of the Social Security Act), the project must require an employer contribution and benefits under the State plan under title XIX of such Act will continue to be made available to the extent they are not available under the employer coverage;

(v) the project provides for coverage of benefits consistent with subsection (b); and

(vi) the project only imposes premiums, coinsurance, and other cost-sharing consistent with subsection (c).

(B) The Secretary may waive the requirements of clause (ii) of this paragraph with respect to those projects described in subparagraph (B) of paragraph (1).

(3) **PERMISSIBLE RESTRICTIONS.**—A project may limit eligibility to individuals whose assets are valued below a level specified by the State. For this purpose, any evaluation of such assets shall be made in a manner consistent with the standards for valuation of assets under the State plan under title XIX of the Social Security Act for individuals entitled to assistance under part A of title IV of such Act. Nothing in this section shall be construed as requiring a State to provide for eligibility for individuals for months before the month in which such eligibility is first established.

(4) **EXTENSION OF ELIGIBILITY.**—A project may provide for extension of eligibility for medical assistance for individuals covered under the project in a manner similar to that provided under section 1925 of the Social Security Act to certain families receiving aid pursuant to a plan of the State approved under part A of title IV of such Act.

(5) **WAIVER OF REQUIREMENTS.**—

(A) **IN GENERAL.**—Subject to subparagraph (B), the Secretary may waive such requirements of title XIX of the Social Security Act (except section 1903(m) of the Social Security Act) as may be required to provide for additional coverage of individuals under projects under this section.

(B) **NONWAIVABLE PROVISIONS.**—Except with respect to those projects described in subparagraph (B) of paragraph (1), the Secretary may not waive, under subparagraph (A), the statewideness requirement of section 1902(a)(1) of the Social Security Act or the Federal medical assistance percentage specified in section 1905(b) of such Act.

(b) **BENEFITS.**—

(1) **IN GENERAL.**—Except as provided in this subsection, the amount, duration, and scope of medical assistance made available under a project shall be the same as the amount, duration, and scope of such assistance made available to individuals entitled to medical assistance under the State plan under section 1902(a)(10)(A)(i) of the Social Security Act.

(2) **LIMITS ON BENEFITS.**—

(A) **REQUIRED.**—Except with respect to those projects described in subparagraph (B) of paragraph (1), no medical assistance shall be made available under a project for nursing facility services or community-based long-term care services (as defined by the Secretary) or for pregnancy-related services. No medical assistance shall be made available under a project to individuals confined to a State correctional facility, county jail, local or county detention center, or other State institution.

(B) **PERMISSIBLE.**—A State, with the approval of the Secretary, may limit or otherwise deny eligibility for medical assistance under the project and may limit coverage of items and services under the project, other than early and periodic screening, diagnostic, and treatment services for children under 18 years of age.

(3) **USE OF UTILIZATION CONTROLS.**—Nothing in this subsection shall be construed as limiting a State's authority to impose controls over utilization of services, including preadmission requirements, managed care provisions, use of preferred providers, and use of second opinions before surgical procedures.

(c) **PREMIUMS AND COST-SHARING.**—

(1) **NONE FOR THOSE WITH INCOME BELOW THE POVERTY LINE.**—Under a project, there shall be no premiums, coinsurance, or other cost-sharing for individuals whose family income level does not exceed 100 percent of the income official poverty line (as defined in subsection (g)(1)) applicable to a family of the size involved.

(2) **LIMIT FOR THOSE WITH INCOME ABOVE THE POVERTY LINE.**—Under a project, for individuals whose family income level exceeds 100 percent, but is less than 150 percent, of the income official poverty line applicable to a family of the size involved, the monthly average amount of premiums, coinsurance, and other cost-sharing for covered items and services shall not exceed 3 percent of the family's average gross monthly earnings.

(3) **INCOME DETERMINATION.**—Each project shall provide for determinations of income in a manner consistent with the methodology used for determinations of income under title XIX of the Social Security Act for individuals entitled to benefits under part A of title IV of such Act.

(d) **DURATION.**—Each project under this section shall commence not later than July 1, 1991 and shall be conducted for a 3-year period; except that the Secretary may terminate such a project if the Secretary determines that the project is not in substantial compliance with the requirements of this section.

(e) **LIMITS ON EXPENDITURES AND FUNDING.**—

(1) **IN GENERAL.**—(A) The Secretary in conducting projects shall limit the total amount of the Federal share of benefits paid and expenses incurred under title XIX of the Social Security Act to no more than \$12,000,000 in each of fiscal years 1991, 1992, and 1993, and to no more than \$4,000,000 in fiscal year 1994.

(B) Of the amounts appropriated under subparagraph (A), the Secretary shall provide that no more than one-third of such amounts shall be used to carry out the projects described in paragraph (1)(B) of subsection (a) (for which the statewideness requirement has been waived).

(2) **NO FUNDING OF CURRENT BENEFICIARIES.**—No funding shall be available under a project with respect to medical assistance provided to individuals who are otherwise eligible for medical assistance under the plan without regard to the project.

(3) **NO INCREASE IN FEDERAL MEDICAL ASSISTANCE PERCENTAGE.**—Payments to a State under a project with respect to expenditures made for medical assistance made available under the project may not exceed the Federal medical assistance percentage (as defined in section 1905(b) of the Social Security Act) of such expenditures.

(f) **EVALUATION AND REPORT.**—

(1) **EVALUATIONS.**—For each project the Secretary shall provide for an evaluation to determine the effect of the project with respect to—

- (A) access to, and costs of, health care,
- (B) private health care insurance coverage, and
- (C) premiums and cost-sharing.

(2) **REPORTS.**—The Secretary shall prepare and submit to Congress an interim report on the status of the projects not later than January 1, 1993, and a final report containing such summary together with such further recommendations as the Sec-

retary may determine appropriate not later than January 1, 1995.

(g) **DEFINITIONS.**—In this section:

(1) The term “income official poverty line” means such line as defined by the Office of Management and Budget and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981.

(2) The term “project” refers to a demonstration project under subsection (a).

SEC. 4746. MEDICAID RESPITE DEMONSTRATION PROJECT EXTENDED.

Section 9414 of the Omnibus Budget Reconciliation Act of 1986 is amended—

(1) by amending subsection (e) to read as follows:

“(e) **DURATION.**—The project under this section may continue until September 30, 1992.”; and

(2) in subsection (d), by striking the last sentence and inserting in lieu thereof the following new sentence: “For the period beginning October 1, 1990, and ending September 30, 1992, Federal payments for the project shall not exceed amounts expended under the project in the preceding fiscal year.”.

42 USC 1396a
note.

SEC. 4747. DEMONSTRATION PROJECT TO PROVIDE MEDICAID COVERAGE FOR HIV-POSITIVE INDIVIDUALS.

(a) **IN GENERAL.**—Not later than 3 months after the date of the enactment of this Act, the Secretary of Health and Human Services (hereafter in this section referred to as the “Secretary”) shall provide for 2 demonstration projects to be administered by States that submit an application under this section, through programs administered by the States under title XIX of the Social Security Act. Such demonstration projects shall provide coverage for the services described in subsection (c) to individuals whose income and resources do not exceed the maximum allowable amount for eligibility for any individual in any category of disability under the State plan under section 1902 of the Social Security Act, and who have tested positive for the presence of HIV virus (without regard to the presence of any symptoms of AIDS or opportunistic diseases related to AIDS).

(b) **SERVICES AVAILABLE UNDER A DEMONSTRATION PROJECT.**—(1) The medical assistance made available to individuals described in section 1902(a)(10)(A) of the Social Security Act shall be made available to individuals described in subsection (a) who receive services under a demonstration project under such paragraph.

(2) A demonstration project under subsection (a) shall provide services in addition to the services described in paragraph (1) which shall be limited only on the basis of medical necessity or the appropriateness of such services. To the extent not provided as described in paragraph (1), such additional services shall include—

(A) general and preventative ⁴⁹ medical care services (including inpatient, outpatient, residential care, physician visits, clinic visits, and hospice care);

(B) prescription drugs, including drugs for the purposes of preventative health care services;

(C) counseling and social services;

(D) substance abuse treatment services (including services for multiple substances abusers);

⁴⁹ So in original. Probably should be “preventive”.

(E) home care services (including assistance in carrying out activities of daily living);

(F) case management;

(G) health education services;

(H) respite care for caregivers;

(I) dental services; and

(J) diagnostic and laboratory services ⁵⁰

(c) AGREEMENTS WITH STATES.—(1) Each State conducting a demonstration project under subsection (a) shall enter into an agreement with a hospital and at least one other nonprofit organization submitting applications to the State. The State shall require that such hospital and other entity have a demonstrated record of case management of patients who have tested positive for the presence of HIV virus and have access to a control group of such type of patients who are not receiving State or Federal payments for medical services (or other payments from private insurance coverage) before developing symptoms of AIDS. Under such agreement, the State shall agree to pay each such entity for the services provided under subsection (b) and not later than 12 months after the commencement of a demonstration project, institute a system of monthly payment to each such entity based on the average per capita cost of the services described in subsection (c) provided to individuals described in paragraphs (1) and (2) of subsection (a).

(2) A demonstration project described in subsection (a) shall be limited to an enrollment of not more than 200 individuals.

(3) A demonstration project conducted under subsection (a) shall commence not later than 9 months after the date of the enactment of this Act and shall terminate on the date that is 3 years after the date of commencement.

(4)(A) The Secretary shall provide for an evaluation of the comparative costs of providing services to individuals who have tested positive for the presence of HIV virus at an early stage after detection of such virus and those that are treated at a later stage after such detection.

(B) The Secretary shall report to Congress on the results of the evaluation conducted under subparagraph (A) no later than 6 months after the date of termination of the demonstration projects described in this section.

(d) FEDERAL SHARE OF COSTS.—The Federal share of the cost of services described in paragraph (3) furnished under a demonstration project conducted under paragraph (1) shall be determined by the otherwise applicable Federal matching assistance percentage pursuant to section 1905(b) of the Social Security Act.

(e) WAIVER OF REQUIREMENTS OF THE SOCIAL SECURITY ACT.—The Secretary may waive such requirements of the Social Security Act as the Secretary determines to be necessary to carry out the purposes of this section.

(f) LIMITATION ON AMOUNT OF EXPENDITURES.—The amount of funds that may be expended as medical assistance to carry out the purposes of this section shall be \$5,000,000 for fiscal year 1991, \$12,000,000 for fiscal year 1992, and \$13,000,000 for fiscal year 1993.

⁵⁰ So in original. Probably should be "services."

Subpart E—Miscellaneous**SEC. 4751. REQUIREMENTS FOR ADVANCED DIRECTIVES UNDER STATE PLANS FOR MEDICAL ASSISTANCE.**

(a) **IN GENERAL.**—Section 1902 (42 U.S.C. 1396a(a)), as amended by sections 4401(a)(2), 4601(d), 4701(a), 4711(a), and 4722 of this title, is amended—

(1) in subsection (a)—

(A) by striking “and” at the end of paragraph (55),

(B) by striking the period at the end of paragraph (56) and inserting “; and”, and

(C) by inserting after paragraph (56) the following new paragraphs:

“(57) provide that each hospital, nursing facility, provider of home health care or personal care services, hospice program, or health maintenance organization (as defined in section 1903(m)(1)(A)) receiving funds under the plan shall comply with the requirements of subsection (w);

“(58) provide that the State, acting through a State agency, association, or other private nonprofit entity, develop a written description of the law of the State (whether statutory or as recognized by the courts of the State) concerning advance directives that would be distributed by providers or organizations under the requirements of subsection (w).”; and

(2) by adding at the end the following new subsection:

“(w)(1) For purposes of subsection (a)(57) and sections 1903(m)(1)(A) and 1919(c)(2)(E), the requirement of this subsection is that a provider or organization (as the case may be) maintain written policies and procedures with respect to all adult individuals receiving medical care by or through the provider or organization—

“(A) to provide written information to each such individual concerning—

“(i) an individual’s rights under State law (whether statutory or as recognized by the courts of the State) to make decisions concerning such medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives (as defined in paragraph (3)), and

“(ii) the provider’s or organization’s written policies respecting the implementation of such rights;

“(B) to document in the individual’s medical record whether or not the individual has executed an advance directive;

“(C) not to condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;

“(D) to ensure compliance with requirements of State law (whether statutory or as recognized by the courts of the State) respecting advance directives; and

“(E) to provide (individually or with others) for education for staff and the community on issues concerning advance directives.

Subparagraph (C) shall not be construed as requiring the provision of care which conflicts with an advance directive.

“(2) The written information described in paragraph (1)(A) shall be provided to an adult individual—

“(A) in the case of a hospital, at the time of the individual’s admission as an inpatient,

“(B) in the case of a nursing facility, at the time of the individual’s admission as a resident,

“(C) in the case of a provider of home health care or personal care services, in advance of the individual coming under the care of the provider,

“(D) in the case of a hospice program, at the time of initial receipt of hospice care by the individual from the program, and

“(E) in the case of a health maintenance organization, at the time of enrollment of the individual with the organization.

“(3) Nothing in this section shall be construed to prohibit the application of a State law which allows for an objection on the basis of conscience for any health care provider or any agent of such provider which as a matter of conscience cannot implement an advance directive.”.⁵¹

“(4) In this subsection, the term ‘advance directive’ means a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State) and relating to the provision of such care when the individual is incapacitated.”.⁵²

(b) CONFORMING AMENDMENTS.—

(1) Section 1903(m)(1)(A) (42 U.S.C. 1396b(m)(1)(A)) is amended—

(A) by inserting “meets the requirement of section 1902(w)” after “which” the first place it appears, and

(B) by inserting “meets the requirement of section 1902(a) and” after “which” the second place it appears.

(2) Section 1919(c)(2) of such Act (42 U.S.C. 1396r(c)(2)) is amended by adding at the end the following new subparagraph:

“(E) INFORMATION RESPECTING ADVANCE DIRECTIVES.—A nursing facility must comply with the requirement of section 1902(w) (relating to maintaining written policies and procedures respecting advance directives).”.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to services furnished on or after the first day of the first month beginning more than 1 year after the date of the enactment of this Act.

42 USC 1396a
note.

(d) PUBLIC EDUCATION CAMPAIGN.—

(1) IN GENERAL.—The Secretary, no later than 6 months after the date of enactment of this section, shall develop and implement a national campaign to inform the public of the option to execute advance directives and of a patient’s right to participate and direct health care decisions.

42 USC 1396a
note.

(2) DEVELOPMENT AND DISTRIBUTION OF INFORMATION.—The Secretary shall develop or approve nationwide informational materials that would be distributed by providers under the requirements of this section, to inform the public and the medical and legal profession of each person’s right to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment, and the existence of advance directives.

(3) PROVIDING ASSISTANCE TO STATES.—The Secretary shall assist appropriate State agencies, associations, or other private entities in developing the State-specific documents that would be distributed by providers under the requirements of this section. The Secretary shall further assist appropriate State

⁵¹ So in original. Probably should be “directive.”.

⁵² So in original. Probably should be “incapacitated.”.

agencies, associations, or other private entities in ensuring that providers are provided a copy of the documents that are to be distributed under the requirements of the section.

(4) DUTIES OF SECRETARY.—The Secretary shall mail information to Social Security recipients, add a page to the medicare handbook with respect to the provisions of this section.

SEC. 4752. IMPROVEMENT IN QUALITY OF PHYSICIAN SERVICES.

(a) USE OF UNIQUE PHYSICIAN IDENTIFIERS.—

(1) ESTABLISHMENT OF SYSTEM.—

(A) IN GENERAL.—Section 1902 (42 U.S.C. 1396a) as amended by sections 4601(d), 4701(a), 4711(a), 4722(a), and 4751(a) is further amended by adding at the end the following new subsection:

“(x) The Secretary shall establish a system, for implementation by not later than July 1, 1991, which provides for a unique identifier for each physician who furnishes services for which payment may be made under a State plan approved under this title.”.

(B) DEADLINE AND CONSIDERATIONS.—The system established under the amendment made by subparagraph (A) may be the same as, or different from, the system established under section 9202(g) of the Consolidated Omnibus Budget Reconciliation Act of 1985.

(2) REQUIRING INCLUSION WITH CLAIMS.—Section 1903(i) (42 U.S.C. 1396b(i)), as amended by this title, is amended—

(A) by striking the period at the end of paragraph (11) and inserting “; or”, and

(B) by inserting after paragraph (11) the following new paragraph:

“(12) with respect to any amount expended for physicians’ services furnished on or after the first day of the first quarter beginning more than 60 days after the date of establishment of the physician identifier system under section 1902(x), unless the claim for the services includes the unique physician identifier provided under such system.”.

(b) MAINTENANCE OF ENCOUNTER DATA BY HEALTH MAINTENANCE ORGANIZATIONS.—

(1) IN GENERAL.—Section 1903(m)(2)(A) (42 U.S.C. 1396b(m)(2)(A)), as amended by this title, is amended—

(A) by striking “and” at the end of clause (ix),

(B) by striking the period at the end of clause (x) and inserting “; and”, and

(C) by adding at the end the following new clause:

“(xi) such contract provides for maintenance of sufficient patient encounter data to identify the physician who delivers services to patients.”.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to contract years beginning after the date of the establishment of the system described in section 1902(x) of the Social Security Act.

(c) MAINTENANCE OF LIST OF PHYSICIANS BY STATES.—

(1) IN GENERAL.—Section 1902(a) (42 U.S.C. 1396a(a)), as amended by this title, is further amended—

(A) by striking “and” at the end of paragraph (56),

(B) by striking the period at the end of paragraph (57) and inserting “; and”, and

42 USC 1396a
note.

42 USC 1396a
note.

(C) by inserting after paragraph (57) the following new paragraph:

“(58) maintain a list (updated not less often than monthly, and containing each physician’s unique identifier provided under the system established under subsection (v)) of all physicians who are certified to participate under the State plan.”.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to medical assistance for calendar quarters beginning more than 60 days after the date of establishment of the physician identifier system under section 1902(x) of the Social Security Act.

42 USC 1396a
note.

(d) FOREIGN MEDICAL GRADUATE CERTIFICATION.—

42 USC 1396a
note.

(1) PASSAGE OF FMGEMS EXAMINATION IN ORDER TO OBTAIN IDENTIFIER.—The Secretary of Health and Human Service⁵³ shall provide, in the identifier system established under section 1902(x) of the Social Security Act, that no foreign medical graduate (as defined in section 1886(h)(5)(D) of such Act) shall be issued an identifier under such system unless the individual—

(A) has passed the FMGEMS examination (as defined in section 1886(h)(5)(E) of such Act);

(B) has previously received certification from, or has previously passed the examination of, the Educational Commission for Foreign Medical Graduates; or

(C) has held a license from 1 or more States continuously since 1958.

(2) EFFECTIVE DATE.—Paragraph (1) shall apply with respect to issuance of an identifier applicable to services furnished on or after January 1, 1992.

(e) MINIMUM QUALIFICATIONS FOR BILLING FOR PHYSICIANS’ SERVICES TO CHILDREN AND PREGNANT WOMEN.—Section 1903(i) (42 U.S.C. 1396b(i)), as amended by this title and subsection (a)(2) of this section, is further amended—

(1) by striking the period at the end of paragraph (13) and inserting “; or”; and

(2) by inserting after paragraph (13) the following new paragraph:

“(14) with respect to any amount expended for physicians’ services furnished by a physician on or after January 1, 1992, to—

“(A) a child under 21 years of age, unless the physician—

“(i) is certified in family practice or pediatrics by the medical specialty board recognized by the American Board of Medical Specialties for family practice or pediatrics,

“(ii) is employed by, or affiliated with, a Federally-qualified health center (as defined in section 1905(l)(2)(B)),

“(iii) holds admitting privileges at a hospital participating in a State plan approved under this title,

“(iv) is a member of the National Health Service Corps,

“(v) documents a current, formal, consultation and referral arrangement with a pediatrician or family practitioner who has the certification described in clause (i) for purposes of specialized treatment and admission to a hospital, or

⁵³ So in original. Probably should be “Services”.

“(vi) has been certified by the Secretary as qualified to provide physicians’ services to a child under 21 years of age; or

“(B) to a pregnant woman (or during the 60 day period beginning on the date of termination of the pregnancy) unless the physician—

“(i) is certified in family practice or obstetrics by the medical specialty board recognized by the American Board of Medical Specialties for family practice or obstetrics,

“(ii) is employed by, or affiliated with, a Federally-qualified health center (as defined in section 1905(l)(2)(B)),

“(iii) holds admitting privileges at a hospital participating in a State plan approved under this title,

“(iv) is a member of the National Health Service Corps,

“(v) documents a current, formal, consultation and referral arrangement with an obstetrician or family practitioner who has the certification described in clause (i) for purposes of specialized treatment and admission to a hospital, or

“(vi) has been certified by the Secretary as qualified to provide physicians’ services to pregnant women.”.

(f) REPORTING OF MISCONDUCT OR SUBSTANDARD CARE.—

(1) **IN GENERAL.**—Section 1921(a) (42 U.S.C. 1396r-2(a)) is amended—

(A) in paragraph (1), in the matter before subparagraph (A), by inserting “(or any peer review organization or private accreditation entity reviewing the services provided by health care practitioners)” after “health care practitioners”; and

(B) in paragraph (1), by adding at the end the following new subparagraph:

“(D) Any negative action or finding by such authority, organization, or entity regarding the practitioner or entity.”.

(2) **EFFECTIVE DATE.**—The amendments made by paragraph (1) shall apply to State information reporting systems as of January 1, 1992, without regard to whether or not the Secretary of Health and Human Services has promulgated any regulations to carry out such amendments by such date.

SEC. 4753. CLARIFICATION OF AUTHORITY OF INSPECTOR GENERAL.

Section 1128A(j) (42 U.S.C. 1320a-7a(j)) is amended—

(1) by striking “(j)” and inserting “(j)(1)”; and

(2) by adding at the end the following new paragraph:

“(2) The Secretary may delegate authority granted under this section and under section 1128 to the Inspector General of the Department of Health and Human Services.”.

SEC. 4754. NOTICE TO STATE MEDICAL BOARDS WHEN ADVERSE ACTIONS TAKEN.

(a) **IN GENERAL.**—Section 1902(a)(41) (42 U.S.C. 1396a(a)(41)) is amended by inserting “and, in the case of a physician and notwithstanding paragraph (7), the State medical licensing board” after “shall promptly notify the Secretary”.

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall apply to sanctions effected more than 60 days after the date of the enactment of this Act. 42 USC 1396a note.

SEC. 4755. MISCELLANEOUS PROVISIONS.

(a) PSYCHIATRIC HOSPITALS.—

(1) CLARIFICATION OF COVERAGE OF INPATIENT PSYCHIATRIC HOSPITAL SERVICES.—

(A) **IN GENERAL.**—Section 1905(h)(1)(A) (42 U.S.C. 1396d(h)(1)(A)), as amended by section 2340(b) of the Deficit Reduction Act of 1984, is amended by inserting “or in another inpatient setting that the Secretary has specified in regulations” after “1861(f)”.

(B) **EFFECTIVE DATE.**—The amendment made by subparagraph (A) shall be effective as if included in the enactment of the Deficit Reduction Act of 1984. 42 USC 1396d note.

(2) INTERMEDIATE SANCTIONS FOR PSYCHIATRIC HOSPITALS.—Section 1902 (42 U.S.C. 1396a) as amended by this title is further amended by adding at the end the following new subsection:

“(y)(1) In addition to any other authority under State law, where a State determines that a psychiatric hospital which is certified for participation under its plan no longer meets the requirements for a psychiatric hospital (referred to in section 1905(h)) and further finds that the hospital’s deficiencies—

“(A) immediately jeopardize the health and safety of its patients, the State shall terminate the hospital’s participation under the State plan; or

“(B) do not immediately jeopardize the health and safety of its patients, the State may terminate the hospital’s participation under the State plan, or provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the effective date of the finding, or both.

“(2) Except as provided in paragraph (3), if a psychiatric hospital described in paragraph (1)(B) has not complied with the requirements for a psychiatric hospital under this title—

“(A) within 3 months after the date the hospital is found to be out of compliance with such requirements, the State shall provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the end of such 3-month period, or

“(B) within 6 months after the date the hospital is found to be out of compliance with such requirements, no Federal financial participation shall be provided under section 1903(a) with respect to further services provided in the hospital until the State finds that the hospital is in compliance with the requirements of this title.

“(3) The Secretary may continue payments, over a period of not longer than 6 months from the date the hospital is found to be out of compliance with such requirements, if—

“(A) the State finds that it is more appropriate to take alternative action to assure compliance of the hospital with the requirements than to terminate the certification of the hospital,

“(B) the State has submitted a plan and timetable for corrective action to the Secretary for approval and the Secretary approves the plan of corrective action, and

“(C) the State agrees to repay to the Federal Government payments received under this paragraph if the corrective action

is not taken in accordance with the approved plan and timetable.”.

42 USC 1396a
note.

(b) STATE UTILIZATION REVIEW SYSTEMS.—Section 9432 of the Omnibus Budget Reconciliation Act of 1986 is amended—

(1) in subsection (a)—

(A) by inserting “(1)” after “IN GENERAL.—”,

(B) by striking “, during the period” and all that follows through “Congress,”, and

(C) by adding at the end the following new paragraph:

“(2) The Secretary may not, during the period beginning on the date of the enactment of the Omnibus Budget Reconciliation Act of 1990 and ending on the date that is 180 days after the date on which the report required by subsection (d) is submitted to the Congress, publish final or interim final regulations requiring a State plan approved under title XIX of the Social Security Act to include a program for ambulatory surgery, preadmission testing, or same-day surgery.”;

(2) in subsection (b)(4), by inserting “and subsection (d)” after “In this subsection”; and

(3) by adding at the end the following new subsection:

“(d) REPORT.—The Secretary shall report to Congress, by not later than January 1, 1993, for each State in a representative sample of States—

“(1) an analysis of the procedures for which programs for ambulatory surgery, preadmission testing, and same-day surgery are appropriate for patients who are covered under the State medicaid plan, and

“(2) the effects of such programs on access of such patients to necessary care, quality of care, and costs of care.

In selecting such a sample of States, the Secretary shall include some States with medicaid plans that include such programs.”.

(c) ADDITIONAL MISCELLANEOUS PROVISIONS.—

(1) Effective July 1, 1990—

42 USC 1396a.

(A) section 1902(a)(10)(C)(iv) of the Social Security Act is amended by striking “through (20)” and inserting “through (21)”, and

(B) section 1902(j) of such Act is amended by striking “through (21)” and inserting “through (22)”.

(2) Effective as if included in subtitle D of title VI of the Omnibus Budget Reconciliation Act of 1989, section 301(j) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 331(j)) is amended by adding at the end the following: “This paragraph does not authorize the withholding of information from either House of Congress or from, to the extent of matter within its jurisdiction, any committee or subcommittee of such committee or any joint committee of Congress or any subcommittee of such joint committee.”.

(3) Section 505(b) (42 U.S.C. 705(b)) is amended in the matter preceding paragraph (1) by striking “requirement” and inserting “requirements”.

PART 5—PROVISIONS RELATING TO NURSING HOME REFORM

SEC. 4801. TECHNICAL CORRECTIONS RELATING TO NURSING HOME REFORM.

(a) NURSE AIDE TRAINING AND COMPETENCY EVALUATION.—

(1) NO COMPLIANCE ACTIONS BEFORE EFFECTIVE DATE OF GUIDELINES.—The Secretary of Health and Human Services shall not take (and shall not continue) any action against a State under section 1904 of the Social Security Act on the basis of the State's failure to meet the requirement of section 1919(e)(1)(A) of such Act before the effective date of guidelines, issued by the Secretary, establishing requirements under section 1919(f)(2)(A) of such Act, if the State demonstrates to the satisfaction of the Secretary that it has made a good faith effort to meet such requirement before such effective date. 42 USC 1396r note.

(2) PART-TIME NURSE AIDES NOT ALLOWED DELAY IN TRAINING.—Section 1919(b)(5)(A) (42 U.S.C. 1396r(b)(5)(A)) is amended—

- (i) by striking "A nursing facility" and inserting "(i) Except as provided in clause (ii), a nursing facility";
- (ii) by striking "(on a full-time, temporary, per diem, or other basis)"⁵⁴ and inserting "on a full-time basis";
- (iii) by striking "(i)" and "(ii)" and inserting "(I)" and "(II)"; and

(iv) by adding at the end the following:

"(ii) A nursing facility must not use on a temporary, per diem, leased, or on any other basis other than as a permanent employee any individual as a nurse aide in the facility on or after January 1, 1991, unless the individual meets the requirements described in clause (i)."

(3) REQUIREMENT TO OBTAIN INFORMATION FROM NURSE AIDE REGISTRY.—Section 1919(b)(5)(C) (42 U.S.C. 1396r(b)(5)(C)) is amended by striking "the State registry established under subsection (e)(2)(A) as to information in the registry" and inserting "any State registry established under subsection (e)(2)(A) that the facility believes will include information".

(4) RETRAINING OF NURSE AIDES.—Section 1919(b)(5)(D) (42 U.S.C. 1396r(b)(5)(D)) is amended by striking the period at the end and inserting ", or a new competency evaluation program."

(5) CLARIFICATION OF NURSE AIDES NOT SUBJECT TO CHARGES.—Section 1919(f)(2)(A)(iv) (42 U.S.C. 1396r(f)(2)(A)(iv)) is amended—

- (A) in subclause (I), by striking "and" at the end;
- (B) in subclause (II), by inserting after "nurse aide" the following: "who is employed by (or who has received an offer of employment from) a facility on the date on which the aide begins either such program";
- (C) in subclause (II), by striking the period at the end and inserting ", and"; and
- (D) by adding at the end the following new subclause:

"(III) in the case of a nurse aide not described in subclause (II) who is employed by (or who has received an offer of employment from) a facility not later than 12 months after completing either such program, the State shall provide for the reimbursement of costs incurred in completing such

⁵⁴ So in original. Probably should be "basis" .

program on a prorata basis during the period in which the nurse aide is so employed.”.

(6) **MODIFICATION OF NURSING FACILITY DEFICIENCY STANDARDS.—**

(A) **IN GENERAL.**—Section 1919(f)(2)(B)(iii)(I) (42 U.S.C. 1396r(f)(2)(B)(iii)(I)) is amended to read as follows:

“(I) offered by or in a nursing facility which, within the previous 2 years—

“(a) has operated under a waiver under subsection (b)(4)(C)(ii) that was granted on the basis of a demonstration that the facility is unable to provide the nursing care required under subsection (b)(4)(C)(i) for a period in excess of 48 hours during a week;

“(b) has been subject to an extended (or partial extended) survey under section 1819(g)(2)(B)(i) or subsection (g)(2)(B)(i); or

“(c) has been assessed a civil money penalty described in section 1819(h)(2)(B)(ii) or subsection (h)(2)(A)(ii) of not less than \$5,000, or has been subject to a remedy described in subsection (h)(1)(B)(i), clauses (i), (iii), or (iv) of subsection (h)(2)(A), clauses (i) or (iii) of section 1819(h)(2)(B), or section 1819(h)(4), or”.

(B) **EFFECTIVE DATE.**—The amendments made by subparagraph (A) shall take effect as if included in the enactment of the Omnibus Budget Reconciliation Act of 1987, except that a State may not approve a training and competency evaluation program or a competency evaluation program offered by or in a nursing facility which, pursuant to any Federal or State law within the 2-year period beginning on October 1, 1988—

(i) had its participation terminated under title XVIII of the Social Security Act or under the State plan under title XIX of such Act;

(ii) was subject to a denial of payment under either such title;

(iii) was assessed a civil money penalty not less than \$5,000 for deficiencies in nursing facility standards;

(iv) operated under a temporary management appointed to oversee the operation of the facility and to ensure the health and safety of the facility’s residents; or

(v) pursuant to State action, was closed or had its residents transferred.

(7) **CLARIFICATION OF STATE RESPONSIBILITY TO DETERMINE COMPETENCY.**—Section 1919(f)(2)(B) (42 U.S.C. 1396r(f)(2)(B)) is amended in the second sentence by inserting “(through sub-contract or otherwise)” after “may not delegate”.

(8) **EXTENSION OF ENHANCED MATCH RATE UNTIL OCTOBER 1, 1990.**—Section 1903(a)(2)(B) (42 U.S.C. 1396b(a)(2)(B)) is amended by striking “July 1, 1990” and inserting “October 1, 1990”.

(9) **EFFECTIVE DATE.**—Except as provided in paragraph (6), the amendments made by this subsection shall take effect as if they were included in the enactment of the Omnibus Budget Reconciliation Act of 1987.

42 USC 1396r
note.

42 USC 1396b
note.

(b) PREADMISSION SCREENING AND ANNUAL RESIDENT REVIEW.—

(1) **NO COMPLIANCE ACTIONS BEFORE EFFECTIVE DATE OF GUIDELINES.—**The Secretary of Health and Human Services shall not take (and shall not continue) any action against a State under section 1904 or section 1919(e)(7)(D) of the Social Security Act on the basis of the State's failure to meet the requirement of section 1919(e)(7)(A) of such Act before the effective date of guidelines, issued by the Secretary, establishing minimum criteria under section 1919(f)(8)(A) of such Act, if the State demonstrates to the satisfaction of the Secretary that it has made a good faith effort to meet such requirement before such effective date.

42 USC 1396r
note.

(2) **CLARIFICATION WITH RESPECT TO ADMISSIONS AND READMISSION FROM A HOSPITAL.—**Section 1919 of the Social Security Act (42 U.S.C. 1396r) is amended—

(A) in subsection (b)(3)(F), by striking “A nursing facility” and by inserting “Except as provided in clauses (ii) and (iii) of subsection (e)(7)(A), a nursing facility”; and

(B) in subsection (e)(7)(A)—

(i) by redesignating the first 2 sentences as clause (i) with the following heading (and appropriate indentation):

“(i) **IN GENERAL.—**”, and

(ii) by adding at the end the following:

“(ii) **CLARIFICATION WITH RESPECT TO CERTAIN READMISSIONS.—**The preadmission screening program under clause (i) need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.

“(iii) **EXCEPTION FOR CERTAIN HOSPITAL DISCHARGES.—**The preadmission screening program under clause (i) shall not apply to the admission to a nursing facility of an individual—

“(I) who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,

“(II) who requires nursing facility services for the condition for which the individual received care in the hospital, and

“(III) whose attending physician has certified, before admission to the facility, that the individual is likely to require less than 30 days of nursing facility services.”.

(3) **DENIAL OF PAYMENTS FOR CERTAIN RESIDENTS NOT REQUIRING NURSING FACILITY SERVICES.—**Section 1919(e)(7) (42 U.S.C. 1395r(e)(7)) is amended—

42 USC 1396r.

(A) in subparagraph (D)—

(i) in the heading, by striking “WHERE FAILURE TO CONDUCT PREADMISSION SCREENING”,

(ii) by designating the first sentence as clause (i) with the following heading (and appropriate indentation):

“(i) **FOR FAILURE TO CONDUCT PREADMISSION SCREENING OR ANNUAL REVIEW.—**”, and

(iii) by adding at the end the following new clause:

“(ii) **FOR CERTAIN RESIDENTS NOT REQUIRING NURSING FACILITY LEVEL OF SERVICES.—**No payment may be made

under section 1903(a) with respect to nursing facility services furnished to an individual (other than an individual described in subparagraph (C)(i)) who does not require the level of services provided by a nursing facility.”; and

(B) in subparagraph (E), by striking “the requirement of this paragraph” and inserting “the requirements of subparagraphs (A) through (C) of this paragraph”.

(4) **NO DELEGATION OF AUTHORITY TO CONDUCT SCREENING AND REVIEWS.**—Section 1919 is further amended—

(A) in subsection (b)(3)(F), by adding at the end the following: “A State mental health authority and a State mental retardation or developmental disability authority may not delegate (by subcontract or otherwise) their responsibilities under this subparagraph to a nursing facility (or to an entity that has a direct or indirect affiliation or relationship with such a facility).”; and

(B) in subsection (e)(7)(B), by adding at the end the following new clause:

“(iv) **PROHIBITION OF DELEGATION.**—A State mental health authority, a State mental retardation or developmental disability authority, and a State may not delegate (by subcontract or otherwise) their responsibilities under this subparagraph to a nursing facility (or to an entity that has a direct or indirect affiliation or relationship with such a facility).”.

(5) **ANNUAL REPORTS.**—

(A) **STATE REPORTS.**—Section 1919(e)(7)(C) (42 U.S.C. 1396r(e)(7)(C)) is amended by adding at the end the following new clause:

“(iv) **ANNUAL REPORT.**—Each State shall report to the Secretary annually concerning the number and disposition of residents described in each of clauses (ii) and (iii).”.

(B) **SECRETARIAL REPORT.**—Section 4215 of the Omnibus Budget Reconciliation Act of 1987 is amended by adding at the end the following new sentence: “Each such report shall also include a summary of the information reported by States under section 1919(e)(7)(C)(iv) of such Act.”.

(6) **REVISION OF ALTERNATIVE DISPOSITION PLANS.**—Section 1919(e)(7)(E) (42 U.S.C. 1396r(e)(7)(E)) is amended by adding at the end the following: “The State may revise such an agreement, subject to the approval of the Secretary, before October 1, 1991, but only if, under the revised agreement, all residents subject to the agreement who do not require the level of services of such a facility are discharged from the facility by not later than April 1, 1994.”.

(7) **DEFINITION OF MENTALLY ILL.**—Section 1919(e)(7)(G)(i) (42 U.S.C. 1396r(e)(7)(G)(i)) is amended—

(A) by striking “primary or secondary” and all that follows through “3rd edition”) and inserting “serious mental illness (as defined by the Secretary in consultation with the National Institute of Mental Health)”,

(B) by inserting before the period “or a diagnosis (other than a primary diagnosis) of dementia and a primary diagnosis that is not a serious mental illness”.

(8) **SUBSTITUTION OF “SPECIALIZED SERVICES” FOR “ACTIVE TREATMENT”.**—Sections 1919(b)(3)(F) and 1919(e)(7) (42 U.S.C. 1396r(b)(3)(F), 1396r(e)(7)) are each amended by striking “active treatment” and “ACTIVE TREATMENT” each place either appears and inserting “specialized services” and “SPECIALIZED SERVICES” respectively.

(9) **EFFECTIVE DATES.**—

42 USC 1396r
note.

(A) **IN GENERAL.**—Except as provided in subparagraph (B), the amendments made by this subsection shall take effect as if they were included in the enactment of the Omnibus Budget Reconciliation Act of 1987.

(B) **EXCEPTION.**—The amendments made by paragraphs (4), (6), and (8) shall take effect on the date of the enactment of this Act, without regard to whether or not regulations to implement such amendments have been promulgated.

42 USC 1396r
note.

(c) **ENFORCEMENT PROCESS.**—The Secretary of Health and Human Services shall not take (and shall not continue) any action against a State under section 1904 of the Social Security Act on the basis of the State’s failure to meet the requirements of section 1919(h)(2) of such Act before the effective date of guidelines, issued by the Secretary, regarding the establishment of remedies by the State under such section, if the State demonstrates to the satisfaction of the Secretary that it has made a good faith effort to meet such requirements before such effective date.

(d) **SUPERVISION OF HEALTH CARE OF RESIDENTS OF NURSING FACILITIES BY NURSE PRACTITIONERS, CLINICAL NURSE SPECIALISTS, AND PHYSICIAN ASSISTANTS ACTING IN COLLABORATION WITH PHYSICIANS.**—

(1) **IN GENERAL.**—Section 1919(b)(6)(A) (42 U.S.C. 1396r(b)(6)(A)) is amended by inserting “(or, at the option of a State, under the supervision of a nurse practitioner, clinical nurse specialist, or physician assistant who is not an employee of the facility but who is working in collaboration with a physician)” after “physician”.

(2) **EFFECTIVE DATE.**—The amendment made by paragraph (1) applies with respect to nursing facility services furnished on or after October 1, 1990, without regard to whether or not final regulations to carry out such amendment have been promulgated by such date.

42 USC 1396r
note.

(e) **OTHER AMENDMENTS.**—

(1) **ASSURANCE OF APPROPRIATE PAYMENT AMOUNTS.**—

(A) **IN GENERAL.**—Section 1902(a)(13)(A) (42 U.S.C. 1396a(a)(13)(A)) is amended by inserting “(including the costs of services required to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident eligible for benefits under this title)” after “take into account the costs”.

(B) **DETAILS IN PLAN AMENDMENT.**—Section 4211(b)(2) of the Omnibus Budget Reconciliation Act of 1987 is amended by inserting after the first sentence the following: “Each such amendment shall include a detailed description of the specific methodology to be used in determining the appropriate adjustment in payment amounts for nursing facility services.”

42 USC 1396a
note.

(2) **DISCLOSURE OF INFORMATION OF QUALITY ASSESSMENT AND ASSURANCE COMMITTEES.**—Section 1919(b)(1)(B) (42 U.S.C. 1396r(b)(1)(B)) is amended by adding at the end the following

new sentence: "A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this subparagraph."

(3) **PERIOD FOR RESIDENT ASSESSMENT.**—Section 1919(b)(3)(C)(i)(I) (42 U.S.C. 1396r(b)(3)(C)(i)(I)) is amended by striking "4 days" and inserting "not later than 14 days".

(4) **CLARIFICATION OF RESPONSIBILITY FOR SERVICES FOR MENTALLY ILL AND MENTALLY RETARDED RESIDENTS.**—Section 1919(b)(4)(A) (42 U.S.C. 1396r(b)(4)(A)) is amended—

(A) by striking "and" at the end of clause (v),

(B) by striking the period at the end of clause (vi) and inserting "; and", and

(C) by inserting after clause (vi) the following new clause:
 "(vii) treatment and services required by mentally ill and mentally retarded residents not otherwise provided or arranged for (or required to be provided or arranged for) by the State."

(5) **CLARIFICATION OF EXTENT OF STATE WAIVER AUTHORITY; NOTIFICATION OF WAIVERS.**—Section 1919(b)(4)(C)(ii) (42 U.S.C. 1396r(b)(4)(C)(ii)) is amended—

(A) by striking "A State" and all that follows through "a facility if" and inserting "To the extent that a facility is unable to meet the requirements of clause (i), a State may waive such requirements with respect to the facility if";

(B) by striking "and" at the end of subclause (II);

(C) by striking the period at the end of subclause (III) and inserting a comma; and

(D) by adding at the end the following new subclauses:

"(IV) the State agency granting a waiver of such requirements provides notice of the waiver to the State long-term care ombudsman (established under section 307(a)(12) of the Older Americans Act of 1965) and the protection and advocacy system in the State for the mentally ill and the mentally retarded, and

"(V) the nursing facility that is granted such a waiver by a State notifies residents of the facility (or, where appropriate, the guardians or legal representatives of such residents) and members of their immediate families of the waiver."

(6) **CLARIFICATION OF DEFINITION OF NURSE AIDE.**—Section 1919(b)(5)(F)(i) (42 U.S.C. 1396r(b)(5)(F)(i)) is amended by striking "(G)," and inserting "(G) or a registered dietician,".

(7) **CHARGES APPLICABLE IN CASES OF CERTAIN MEDICAID-ELIGIBLE INDIVIDUALS.**—

(A) **IN GENERAL.**—Section 1919(c) (42 U.S.C. 1396r(c)) is amended—

(i) by redesignating paragraph (7) as paragraph (8); and

(ii) by inserting after paragraph (6) the following new paragraph:

"(7) **LIMITATION ON CHARGES IN CASE OF MEDICAID-ELIGIBLE INDIVIDUALS.**—

"(A) **IN GENERAL.**—A nursing facility may not impose charges, for certain medicaid-eligible individuals for nursing facility services covered by the State under its plan

under this title, that exceed the payment amounts established by the State for such services under this title.

“(B) CERTAIN MEDICAID INDIVIDUALS DEFINED.—In subparagraph (A), the term ‘certain medicaid-eligible individual’ means an individual who is entitled to medical assistance for nursing facility services in the facility under this title but with respect to whom such benefits are not being paid because, in determining the amount of the individual’s income to be applied monthly to payment for the costs of such services, the amount of such income exceeds the payment amounts established by the State for such services under this title.”.

(B) EFFECTIVE DATE.—The amendments made by subparagraph (A) shall take effect on the date of the enactment of this Act, without regard to whether or not regulations to implement such amendments have been promulgated. 42 USC 1396r note.

(8) RESIDENTS’ RIGHTS TO REFUSE INTRA-FACILITY TRANSFERS TO MOVE THE RESIDENT TO A MEDICARE-QUALIFIED PORTION.—Section 1919(c)(1)(A) (42 U.S.C. 1396r(c)(1)(A)) is amended—

(A) by redesignating clause (x) as clause (xi) and by inserting after clause (ix) the following new clause:

“(x) REFUSAL OF CERTAIN TRANSFERS.—The right to refuse a transfer to another room within the facility, if a purpose of the transfer is to relocate the resident from a portion of the facility that is not a skilled nursing facility (for purposes of title XVIII) to a portion of the facility that is such a skilled nursing facility.”; and

(B) by adding at the end the following: “A resident’s exercise of a right to refuse transfer under clause (x) shall not affect the resident’s eligibility or entitlement to medical assistance under this title or a State’s entitlement to Federal medical assistance under this title with respect to services furnished to such a resident.”.

(9) RESIDENT ACCESS TO CLINICAL RECORDS.—Section section ⁵⁵ 1919(c)(1)(A)(iv) (42 U.S.C. 1396r(c)(1)(A)(iv)) is amended by inserting before the period at the end the following: “and to access to current clinical records of the resident upon request by the resident or the resident’s legal representative, within 24 hours (excluding hours occurring during a weekend or holiday) after making such a request”.

(10) INCLUSION OF STATE NOTICE OF RIGHTS IN FACILITY NOTICE OF RIGHTS.—Section 1919(c)(1)(B)(ii) (42 U.S.C. 1396r(c)(1)(B)(ii)) is amended by inserting “including the notice (if any) of the State developed under subsection (e)(6)” after “in such rights”.

(11) REMOVAL OF DUPLICATIVE REQUIREMENT FOR QUALIFICATIONS OF NURSING HOME ADMINISTRATORS.—Effective on the date on which the Secretary promulgates standards regarding the qualifications of nursing facility administrators under section 1919(f)(4) of the Social Security Act—

(A) paragraph (29) of section 1902(a) of such Act (42 U.S.C. 1396a(a)) is repealed; and

(B) section 1908 of such Act (42 U.S.C. 1396g) is repealed.

(12) CLARIFICATION OF NURSE AIDE REGISTRY REQUIREMENTS.—Section 1919(e)(2) (42 U.S.C. 1396r(e)(2)) is amended—

(A) in subparagraph (A), by striking the period and inserting the following: “, or any individual described in subsec-

⁵⁵ So in original. Probably should be “Section 1919(c)(1)(A)(iv)”.

tion (f)(2)(B)(ii) or in subparagraph (B), (C), or (D) of section 6901(b)(4) of the Omnibus Budget Reconciliation Act of 1989.”; and

(B) by adding at the end the following new subparagraph:

“(C) PROHIBITION AGAINST CHARGES.—A State may not impose any charges on a nurse aide relating to the registry established and maintained under subparagraph (A).”.

(13) CLARIFICATION ON FINDINGS OF NEGLECT.—Section 1919(g)(1)(C) (42 U.S.C. 1396r(g)(1)(C)) is amended by adding at the end the following: “A State shall not make a finding that an individual has neglected a resident if the individual demonstrates that such neglect was caused by factors beyond the control of the individual.”.

(14) TIMING OF PUBLIC DISCLOSURE OF SURVEY RESULTS.—Section 1919(g)(5)(A)(i) (42 U.S.C. 1396r(g)(5)(A)(i)) is amended by striking “deficiencies and plans” and inserting “deficiencies, within 14 calendar days after such information is made available to those facilities, and approved plans”.

(15) OMBUDSMAN PROGRAM COORDINATION WITH STATE SURVEY AND CERTIFICATION AGENCIES.—Section 1919(g)(5)(B) (42 U.S.C. 1396r(g)(5)(B)) is amended by striking “with respect” and inserting “or of any adverse action taken against a nursing facility under paragraphs (1), (2), or (3) of subsection (h), with respect”.

(16) DENIAL OF PAYMENT OF LEGAL FEES FOR FRIVOLOUS LITIGATION.—

(A) IN GENERAL.—Section 1903(i) (42 U.S.C. 1396b(i)), [[as amended by section X??? (a)(1)(B) of this Act]], is amended—

(i) by striking “or” at the end of paragraph (9);

(ii) by striking the period at the end of paragraph (10) and inserting “; or”; and

(iii) by inserting after paragraph (10) the following new paragraph:

“(11) with respect to any amount expended to reimburse (or otherwise compensate) a nursing facility for payment of legal expenses associated with any action initiated by the facility that is dismissed on the basis that no reasonable legal ground existed for the institution of such action.”

(B) EFFECTIVE DATE.—The amendments made by subparagraph (A) shall apply with respect to actions initiated on or after the date of the enactment of this Act.

(17) PROVISIONS RELATING TO STAFFING REQUIREMENTS.—

(A) MAINTAINING REGULATORY STANDARDS FOR CERTAIN SERVICES.—Any regulations promulgated and applied by the Secretary of Health and Human Services after the date of the enactment of the Omnibus Budget Reconciliation Act of 1987 with respect to services described in clauses (ii), (iv), and (v) of section 1919(b)(4)(A) of the Social Security Act shall include requirements for providers of such services that are at least as strict as the requirements applicable to providers of such services prior to the enactment of the Omnibus Budget Reconciliation Act of 1987.

(B) STUDY ON STAFFING REQUIREMENTS IN NURSING FACILITIES.—The Secretary shall conduct a study and report to Congress no later than January 1, 1992, on the appropriateness of establishing minimum caregiver to resident ratios and minimum supervisor to caregiver ratios for skilled nursing facilities serving as providers of services under title

42 USC 1396b
note.

42 USC 1396r
note.

XVIII of the Social Security Act and nursing facilities receiving payments under a State plan under title XIX of the Social Security Act, and shall include in such study recommendations regarding appropriate minimum ratios.

(18) **STATE REQUIREMENTS RELATING TO PROGRAMS.**—Amend 1919(e)(1)(A) to strike “under clause (i) or (ii) of subsection (f)(2)(A) and insert “under subsection (f)(2)”. 42 USC 1396r.

(19) **EFFECTIVE DATES.**—Except as provided in paragraphs (7), (11), and (16), the amendments made by this subsection shall take effect as if they were included in the enactment of the Omnibus Budget Reconciliation Act of 1987. 42 USC 1396a note.

TITLE V—INCOME SECURITY, HUMAN RESOURCES, AND RELATED PROGRAMS

Subtitle A—Human Resource and Family Policy Amendments

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SEC. 502. AMENDMENT OF SOCIAL SECURITY ACT.

Except as otherwise expressly provided, wherever in this subtitle an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Social Security Act.

CHAPTER 1—CHILD SUPPORT ENFORCEMENT

SEC. 5011. EXTENSION OF IRS INTERCEPT FOR NON-AFDC FAMILIES.

(a) **AUTHORITY OF STATES TO REQUEST WITHHOLDING OF FEDERAL TAX REFUNDS FROM PERSONS OWING PAST DUE CHILD SUPPORT.**—Section 464(a)(2)(B) (42 U.S.C. 664(a)(2)(B)) is amended by striking “, and before January 1, 1991”.

(b) **WITHHOLDING OF FEDERAL TAX REFUNDS AND COLLECTION OF PAST DUE CHILD SUPPORT ON BEHALF OF DISABLED CHILD OF ANY AGE, AND OF SPOUSAL SUPPORT INCLUDED IN ANY CHILD SUPPORT ORDER.**—Section 464(c) (42 U.S.C. 664(c)) is amended—

(1) in paragraph (2), by striking “minor child.” and inserting “qualified child (or a qualified child and the parent with whom the child is living if the same support order includes support for the child and the parent).”; and

(2) by adding at the end the following:

“(3) For purposes of paragraph (2), the term ‘qualified child’ means a child—

“(A) who is a minor; or

“(B)(i) who, while a minor, was determined to be disabled under title II or XVI; and

“(ii) for whom an order of support is in force.”.

(c) **EFFECTIVE DATE.**—The amendments made by subsection (b) shall take effect on January 1, 1991.

SEC. 5012. EXTENSION OF COMMISSION ON INTERSTATE CHILD SUPPORT.

(a) **REAUTHORIZATION.**—Section 126 of the Family Support Act of 1988 (42 U.S.C. 666 note; Public Law 100-485) is amended—

(1) in subsection (d)—

(A) in paragraph (1), by striking “1990” and inserting “1991”; and

(B) in paragraph (2), by striking “1991” and inserting “1992”;

(2) in subsection (e), by adding at the end the following:

“(5)(A) Individuals may be appointed to serve the Commission without regard to the provisions of title 5 that govern appointments in the competitive service, without regard to the competitive service, and without regard to the classification system in chapter 53 of title 5, United States Code. The chairman of the Commission may fix the compensation of the Executive Director at a rate that shall not exceed the maximum rate of the basic pay payable under GS-18 of the General Schedule as contained in title 5, United States Code.

“(B) The Executive Director may appoint and fix the compensation of such additional personnel as the Executive Director considers necessary to carry out the duties of the Commission. Such personnel may be appointed without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and may be paid without regard to the provisions of chapter 51 and subchapter III of chapter 53 of such title relating to classification and General Schedule pay rates.

“(C) On the request of the chairman, the head of any Federal department or agency may detail, on a reimbursable basis, any of the personnel of such agency to the Commission to assist the Commission in carrying out its duties under this section without regard to section 3341 of title 5, United States Code.”; and

(3) in subsection (f)(1), by striking “1991” and inserting “1992”.

(b) **EFFECTIVE DATE.**—The amendments made by subsection (a) shall take effect on the date of the enactment of this Act. 42 USC 666 note.

SEC. 5013. CHILD SUPPORT ENFORCEMENT WAIVER.

(a) **IN GENERAL.**—The Secretary of Health and Human Services (in this section referred to as the “Secretary”) shall enter into an agreement with the State of Texas waiving (with respect to cases where a court has issued an order for child support) the following requirements under the State plan for child and spousal support that are described in subparagraphs (A) and (B) of section 454(6) of the Social Security Act, with respect to a project, based in the county of Bexar, of delinquency monitoring for child support enforcement:

(1) The submission of a written application by an individual requesting child support collection services.

(2) The payment of an application fee with respect to an application for such services.

(b) **CONTENTS OF WAIVER AGREEMENT.**—In the agreement between the Secretary and the State of Texas described in subsection (a), the waiver granted under such agreement shall provide the following:

(1) The waiver shall apply only with respect to the provision of child support collection services.

(2) Before the provision of any child support collection services, the organizational unit designated under section 454(3) of the Social Security Act (in this section referred to as the “State

agency”) shall provide written notification to each custodial parent of the right of such parent to refuse such services.

(3) The State shall ensure that, to the extent possible, each parent of the child on behalf of whom such services are provided (regardless of whether such parent is a custodial parent) is to receive written notice at the time such services are provided, explaining—

(A) the legal rights of parents with respect to the child support collection services provided; and

(B) the responsibilities of the State agency in providing such child support collection services (including the monitoring of delinquent child support payments).

(4) A case record shall be deemed to have been established by the State agency upon notification of a custodial parent of the option to receive the child support enforcement services described in this subsection.

(5) Any period of enforcement by the State agency under this section with respect to the collection of delinquent child support payments shall be deemed to begin on the first day of any such delinquency.

(d) STUDY AND REPORT.—

(1) **STUDY REQUIRED.**—As a condition precedent to granting the waiver described in subsection (a), the State agency shall agree to conduct a study of the cost-effectiveness to the Federal Government and to the State of Texas of the monitoring of delinquent child support payments under the State plan under section 454 of the Social Security Act.

(2) CONDUCT OF STUDY.—

(A) **IN GENERAL.**—The study required by paragraph (1) shall be conducted in accordance with the criteria established by the Secretary in accordance with subparagraph (B).

(B) **CRITERIA.**—Not later than February 1, 1991, the Secretary shall establish the criteria required by subparagraph (A), in consultation with—

(i) 1 or more representatives of organizations representing child support administrators;

(ii) 1 or more representatives of the General Accounting Office;

(iii) 1 or more representatives of the State of Texas; and

(iv) such other individuals or organizations with experience in the evaluation of child support programs, as the Secretary may designate.

(3) **REPORT.**—Not later than 3 months after the expiration of the waiver described in subsection (a), the State agency shall submit to the Secretary and to the Congress a report that includes the findings of the study required by this subsection.

(e) **DURATION OF WAIVER.**—The waiver described in subsection (a) shall be effective for not more than 2 years.

(f) MATCHING PAYMENTS.—

(1) **GENERAL EXPENDITURES.**—In lieu of any payment under section 455 of the Social Security Act with respect to expenditures of the State of Texas to carry out child support enforcement programs with respect to which the waiver described in subsection (a) applies, the Secretary shall pay the State an amount equal to the lesser of—

- (A) 66 percent of such expenditures; or
- (B) \$500,000.

(2) **STUDY EXPENDITURES.**—In lieu of any payment under section 455 of the Social Security Act with respect to expenditures of the State of Texas to carry out the study required by subsection (d), the Secretary shall pay the State an amount equal to 66 percent of such expenditures.

CHAPTER 2—UNEMPLOYMENT COMPENSATION

SEC. 5021. AMOUNTS TRANSFERRED TO STATE UNEMPLOYMENT COMPENSATION PROGRAM ACCOUNTS.

(a) **ALLOCATION OF AMOUNTS.**—Paragraph (2) of section 903(a) (42 U.S.C. 1103(a)(2)) is amended to read as follows:

“(2) Each State’s share of the funds to be transferred under this subsection as of any October 1—

“(A) shall be determined by the Secretary of Labor and certified by such Secretary to the Secretary of the Treasury before such date, and

“(B) shall bear the same ratio to the total amount to be so transferred as—

“(i) the amount of wages subject to tax under section 3301 of the Internal Revenue Code of 1986 during the preceding calendar year which are determined by the Secretary of Labor to be attributable to the State, bears to

“(ii) the total amount of wages subject to such tax during such year.”

(b) **USE OF TRANSFERRED AMOUNTS.**—Paragraph (2) of section 903(c) (42 U.S.C. 1103(c)(2)) is amended—

- (1) by striking “and” at the end of subparagraph (C), and
- (2) by striking so much of such paragraph as follows subparagraph (C) and inserting the following:

“(D)(i) the appropriation law limits the total amount which may be obligated under such appropriation at any time to an amount which does not exceed, at any such time, the amount by which—

“(I) the aggregate of the amounts transferred to the account of such State pursuant to subsections (a) and (b), exceeds

“(II) the aggregate of the amounts used by the State pursuant to this subsection and charged against the amounts transferred to the account of such State, and

“(ii) for purposes of clause (i), amounts used by a State for administration shall be chargeable against transferred amounts at the exact time the obligation is entered into, and

“(E) the use of the money is accounted for in accordance with standards established by the Secretary of Labor.”

(c) **EFFECTIVE DATE.**—The amendments made by this section shall apply to fiscal years beginning after the date of the enactment of this Act. 42 USC 1103 note.

CHAPTER 3—SUPPLEMENTAL SECURITY INCOME

SEC. 5031. EXCLUSION FROM INCOME AND RESOURCES OF VICTIMS' COMPENSATION PAYMENTS.

(a) **EXCLUSION FROM INCOME.**—Section 1612(b) (42 U.S.C. 1382a(b)) is amended—

- (1) by striking “and” at the end of paragraph (15);
- (2) by striking the period at the end of paragraph (16) and inserting “; and”; and
- (3) by adding at the end the following:

“(17) any amount received by such individual (or such spouse) from a fund established by a State to aid victims of crime.”.

(b) **EXCLUSION FROM RESOURCES.**—Section 1613(a) (42 U.S.C. 1382b(a)) is amended—

- (1) by striking “and” at the end of paragraph (7);
- (2) by striking the period at the end of paragraph (8) and inserting “; and”; and
- (3) by adding at the end the following:

“(9) for the 9-month period beginning after the month in which received, any amount received by such individual (or such spouse) from a fund established by a State to aid victims of crime, to the extent that such individual (or such spouse) demonstrates that such amount was paid as compensation for expenses incurred or losses suffered as a result of a crime.”.

(c) **VICTIMS COMPENSATION AWARD NOT REQUIRED TO BE ACCEPTED AS CONDITION OF RECEIVING BENEFITS.**—Section 1631(a) (42 U.S.C. 1383(a)) is amended by adding at the end the following:

“(9) Benefits under this title shall not be denied to any individual solely by reason of the refusal of the individual to accept an amount offered as compensation for a crime of which the individual was a victim.”

42 USC 1382a
note.

(d) **EFFECTIVE DATE.**—The amendments made by this section shall apply with respect to benefits for months beginning on or after the first day of the 6th calendar month following the month in which this Act is enacted.

SEC. 5032. ATTAINMENT OF AGE 65 NOT TO SERVE AS BASIS FOR TERMINATION OF ELIGIBILITY UNDER SECTION 1619(b).

42 USC 1382h.

(a) **IN GENERAL.**—Section 1619(b)(1) (42 U.S.C. 1392h(b)(1)) is amended by striking “under age 65”.

42 USC 1382h
note.

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall apply with respect to benefits for months beginning on or after the first day of the 6th calendar month following the month in which this Act is enacted.

SEC. 5033. EXCLUSION FROM INCOME OF IMPAIRMENT-RELATED WORK EXPENSES.

(a) **IN GENERAL.**—Section 1612(b)(4)(B)(ii) (42 U.S.C. 1382a(b)(4)(B)(ii)) is amended by striking “(for purposes of determining the amount of his or her benefits under this title and of determining his or her eligibility for such benefits for consecutive months of eligibility after the initial month of such eligibility)”.

42 USC 1382a
note.

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall apply to benefits payable for calendar months beginning after the date of the enactment of this Act.

SEC. 5034. TREATMENT OF ROYALTIES AND HONORARIA AS EARNED INCOME.

(a) **IN GENERAL.**—Section 1612(a) (42 U.S.C. 1382a(a)) is amended—

(1) in paragraph (1)—

(A) by striking “and” at the end of subparagraph (C); and

(B) by adding at the end the following:

“(E) any royalty earned by an individual in connection with any publication of the work of the individual, and that portion of any honorarium which is received for services rendered; and”; and

(2) in paragraph (2)(F), by inserting “not described in paragraph (1)(E)” before the period.

(b) **EFFECTIVE DATE.**—The amendments made by subsection (a) shall apply with respect to benefits for months beginning on or after the first day of the 13th calendar month following the month in which this Act is enacted. 42 USC 1382a note.

SEC. 5035. CERTAIN STATE RELOCATION ASSISTANCE EXCLUDED FROM SSI INCOME AND RESOURCES.

(a) **EXCLUSION FROM INCOME.**—Section 1612(b) (42 U.S.C. 1382a(b)), as amended by section 5031(a) of this Act, is amended—

(1) by striking “and” at the end of paragraph (16);

(2) by striking the period at the end of paragraph (17) and inserting a semicolon; and

(3) by inserting after paragraph (17) the following:

“(18) relocation assistance provided by a State or local government to such individual (or such spouse), comparable to assistance provided under title II of the Uniform Relocation Assistance and Real Property Acquisitions Policies Act of 1970 which is subject to the treatment required by section 216 of such Act.”.

(b) **EXCLUSION FROM RESOURCES.**—Section 1613(a) (42 U.S.C. 1382b(a)), as amended by section 5031(b) of this Act, is amended—

(1) by striking “and” at the end of paragraph (8);

(2) by striking the period at the end of paragraph (9) and inserting “; and”; and

(3) by inserting after paragraph (9) the following:

“(10) for the 9-month period beginning after the month in which received, relocation assistance provided by a State or local government to such individual (or such spouse), comparable to assistance provided under title II of the Uniform Relocation Assistance and Real Property Acquisitions Policies Act of 1970 which is subject to the treatment required by section 216 of such Act.”.

(c) **EFFECTIVE DATE.**—The amendments made by this section shall apply with respect to benefits for calendar months beginning in the 3-year period that begins on the first day of the 6th calendar month following the month in which this Act is enacted. 42 USC 1382a note.

SEC. 5036. EVALUATION OF CHILD'S DISABILITY BY PEDIATRICIAN OR OTHER QUALIFIED SPECIALIST.

(a) **IN GENERAL.**—Section 1614(a)(3) (42 U.S.C. 1382c(a)(3)) is amended by adding at the end the following:

“(H) In making any determination under this title with respect to the disability of a child who has not attained the age of 18 years and to whom section 221(h) does not apply, the Secretary shall make reasonable efforts to ensure that a qualified pediatrician or other

individual who specializes in a field of medicine appropriate to the disability of the child (as determined by the Secretary) evaluates the case of such child.”.

42 USC 1382c
note.

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall apply to determinations made 6 or more months after the date of the enactment of this Act.

SEC. 5037. REIMBURSEMENT FOR VOCATIONAL REHABILITATION SERVICES FURNISHED DURING CERTAIN MONTHS OF NONPAYMENT OF SSI BENEFITS.

(a) **IN GENERAL.**—Section 1615 (42 U.S.C. 1382d) is amended by adding at the end the following:

“(e) The Secretary may reimburse the State agency described in subsection (d) for the costs described therein incurred in the provision of rehabilitation services—

“(1) for any month for which an individual received—

“(A) benefits under section 1611 or 1619(a);

“(B) assistance under section 1619(b); or

“(C) a federally administered State supplementary payment under section 1616 of this Act or section 212(b) of Public Law 93-66; and

“(2) for any month before the 13th consecutive month for which an individual, for a reason other than cessation of disability or blindness, was ineligible for—

“(A) benefits under section 1611 or 1619(a);

“(B) assistance under section 1619(b); or

“(C) a federally administered State supplementary payment under section 1616 of this Act or section 212(b) of Public Law 93-66.”.

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall take effect on the date of the enactment of this Act and shall apply to claims for reimbursement pending on or after such date.

SEC. 5038. EXTENSION OF PERIOD OF PRESUMPTIVE ELIGIBILITY FOR BENEFITS.

(a) **IN GENERAL.**—Section 1631(a)(4)(B) (42 U.S.C. 1383(a)(4)(B)) is amended by striking “3” and inserting “6”.

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall apply with respect to benefits for months beginning on or after the first day of the 6th calendar month following the month in which this Act is enacted.

SEC. 5039. CONTINUING DISABILITY OR BLINDNESS REVIEWS NOT REQUIRED MORE THAN ONCE ANNUALLY.

(a) **IN GENERAL** ⁵⁶—Section 1619 (42 U.S.C. 1382h) is amended—

(1) by redesignating subsection (c) as subsection (d); and

(2) by inserting after subsection (b) the following:

“(c) Subsection (a)(2) and section 1631(j)(2)(A) shall not be construed, singly or jointly, to require more than 1 determination during any 12-month period with respect to the continuing disability or blindness of an individual.”.

(b) **CONFORMING AMENDMENT.**—Section 1631(j)(2)(A) (42 U.S.C. 1383(j)(2)(A)) is amended by inserting “(other than subsection (c) thereof)” after “1619” the 1st place such term appears.

(c) **EFFECTIVE DATE.**—The amendments made by this section shall take effect on the date of the enactment of this Act.

42 USC 1382d
note.

42 USC 1383
note.

42 USC 1382h
note.

⁵⁶ So in original. Probably should be “GENERAL.—”.

SEC. 5040. CONCURRENT SSI AND FOOD STAMP APPLICATIONS BY INSTITUTIONALIZED INDIVIDUALS.

Section 1631 (42 U.S.C. 1383) is amended—

- (1) in subsection (m), by striking the second sentence; and
- (2) by adding at the end the following:

**“CONCURRENT SSI AND FOOD STAMP APPLICATIONS BY
INSTITUTIONALIZED INDIVIDUALS**

“(n) The Secretary and the Secretary of Agriculture shall develop a procedure under which an individual who applies for supplemental security income benefits under this subsection shall also be permitted to apply at the same time for participation in the food stamp program authorized under the Food Stamp Act of 1977 (7 U.S.C. 2011 et seq.).”

SEC. 5041. NOTIFICATION OF CERTAIN INDIVIDUALS ELIGIBLE TO RECEIVE RETROACTIVE BENEFITS.

In notifying individuals of their eligibility to receive retroactive supplemental security income benefits as a result of *Sullivan v. Zebley*, 110 S. Ct. 2658 (1990), the Secretary shall include written notice, in language that is easily understandable, explaining—

(1) the 6-month limitation on the exclusion from resources under section 1613(a)(7) of the Social Security Act (42 U.S.C. 1382b(a)(7));

(2) the potential effects under title XVI of the Social Security Act, attributable to the receipt of such payment, including—

(A) potential discontinuation of eligibility; and

(B) potential reductions in the amount of benefits;

(3) the possibility of establishing a trust account that would not be considered as income or resources for the purposes of such title if the trust met certain conditions; and

(4) that legal assistance in establishing such a trust may be available through legal referral services offered by a State or local bar association, or through the Legal Services Corporation.

**CHAPTER 4—AID TO FAMILIES WITH DEPENDENT
CHILDREN**

SEC. 5051. OPTIONAL MONTHLY REPORTING AND RETROSPECTIVE BUDGETING.

(a) **OPTIONAL MONTHLY REPORTING.**—Section 402(a)(14) (42 U.S.C. 602(a)(14)) is amended—

(1) by striking “with respect to” and all that follows through “(A) provide” and insert “provide, at the option of the State and with respect to such category or categories as the State may select and identify in its State plan (A)”;

(2) by striking “(with the prior approval of the Secretary in recent work history and earned income cases)”;

(3) by striking “upon a determination” and all that follows through “paragraph”.

(b) **OPTIONAL RETROSPECTIVE BUDGETING.**—Section 402(a)(13) (42 U.S.C. 602(a)(13)) is amended by striking all that precedes subparagraph (A) and inserting the following:

“(13) at the option of the State, but only with respect to any one or more categories of families required to report monthly to the State agency pursuant to paragraph (14), provide that—”

42 USC 602 note.

(c) **EFFECTIVE DATE.**—The amendments made by this section shall take effect with respect to reports pertaining to, or aid payable for, months beginning in or after October 1990.

SEC. 5052. CHILDREN RECEIVING FOSTER CARE MAINTENANCE OR ADOPTION ASSISTANCE PAYMENTS NOT TREATED AS MEMBER OF FAMILY UNIT FOR PURPOSES OF DETERMINING ELIGIBILITY FOR, OR AMOUNT OF, AFDC BENEFIT.

(a) **IN GENERAL.**—Part A of title IV (42 U.S.C. 601 et seq.) is amended by inserting after section 408 the following:

“EXCLUSION FROM AFDC UNIT OF CHILD FOR WHOM FEDERAL, STATE, OR LOCAL FOSTER CARE MAINTENANCE OR ADOPTION ASSISTANCE PAYMENTS ARE MADE

42 USC 609.

“SEC. 409. (a) Notwithstanding any other provision of this title (other than subsection (b))—

“(1) a child with respect to whom foster care maintenance payments or adoption assistance payments are made under part E or under State or local law shall not, for the period for which such payments are made, be regarded as a member of a family for purposes of determining the amount of benefits of the family under this part; and

“(2) the income and resources of such child shall be excluded from the income and resources of a family under this part.

“(b) Subsection (a) shall not apply in the case of a child with respect to whom adoption assistance payments are made under part E or under State or local law, if application of such subsection would reduce the benefits under this part of the family of which the child would otherwise be regarded as a member.”

(b) **CONFORMING REPEAL.**—Section 478 (42 U.S.C. 678) is hereby repealed.

42 USC 609 note.

(c) **EFFECTIVE DATE.**—The amendment made by subsection (a) and the repeal made by subsection (b) shall apply with respect to benefits for months beginning on or after the first day of the 6th calendar month following the month in which this Act is enacted.

SEC. 5053. ELIMINATION OF TERM “LEGAL GUARDIAN”.

(a) **IN GENERAL.**—Section 402(a)(39) (42 U.S.C. 602(a)(39)) is amended—

(1) by striking “or legal guardian”; and

(2) by striking “or legal guardians”.

42 USC 602 note.

(b) **EFFECTIVE DATE.**—The amendments made by subsection (a) shall take effect on the date of the enactment of this Act.

SEC. 5054. REPORTING OF CHILD ABUSE AND NEGLECT.

(a) **CONCERNING AFDC APPLICANTS AND RECIPIENTS.**—

(1) **IN GENERAL.**—Section 402(a)(16) (42 U.S.C. 602(a)(16)) is amended to read as follows:

“(16) provide that the State agency will—

“(A) report to an appropriate agency or official, known or suspected instances of physical or mental injury, sexual abuse or exploitation, or negligent treatment or maltreatment of a child receiving aid under this part under circumstances which indicate that the child’s health or welfare is threatened thereby; and

“(B) provide such information with respect to a situation described in subparagraph (A) as the State agency may have;”.

(2) CONFORMING AMENDMENTS.—Section 402(a)(9) (42 U.S.C. 602(a)(9)) is amended—

(A) in subparagraph (C), by striking “and”; and

(B) by inserting “, and (E) reporting and providing information pursuant to paragraph (16) to appropriate authorities with respect to known or suspected child abuse or neglect” before the 1st semicolon.

(b) CONCERNING RECIPIENTS OF FOSTER CARE OR ADOPTION ASSISTANCE.—

(1) IN GENERAL.—Section 471(a)(9) (42 U.S.C. 671(a)(9)) is amended to read as follows:

“(9) provides that the State agency will—

“(A) report to an appropriate agency or official, known or suspected instances of physical or mental injury, sexual abuse or exploitation, or negligent treatment or maltreatment of a child receiving aid under part B or this part under circumstances which indicate that the child’s health or welfare is threatened thereby; and

“(B) provide such information with respect to a situation described in subparagraph (A) as the State agency may have;”.

(2) CONFORMING AMENDMENTS.—Section 471(a)(8) (42 U.S.C. 671(a)(8)) is amended—

(A) in subparagraph (C), by striking “and”; and

(B) by inserting “, and (E) reporting and providing information pursuant to paragraph (9) to appropriate authorities with respect to known or suspected child abuse or neglect” before the 1st semicolon.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to benefits for months beginning on or after the first day of the 6th calendar month following the month in which this Act is enacted. 42 USC 602 note.

SEC. 5055. DISCLOSURE OF INFORMATION ABOUT AFDC APPLICANTS AND RECIPIENTS AUTHORIZED FOR PURPOSES DIRECTLY CONNECTED TO STATE FOSTER CARE AND ADOPTION ASSISTANCE PROGRAMS.

(a) IN GENERAL.—Section 402(a)(9)(A) (42 U.S.C. 602(a)(9)(A)) is amended by striking “or D” and inserting “, D, or E”.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date of the enactment of this Act. 42 USC 602 note.

SEC. 5056. REPATRIATION.

(a) IN GENERAL.—Section 1113 (42 U.S.C. 1313) is amended—

(1) in subsection (d), by striking “on or after October 1, 1989” and inserting “after September 30, 1991”; and

(2) by adding at the end the following:

“(e)(1) The Secretary may accept on behalf of the United States gifts, in cash or in kind, for use in carrying out the program established under this section. Gifts in the form of cash shall be credited to the appropriation account from which this program is funded, in addition to amounts otherwise appropriated, and shall remain available until expended.

42 USC 1313
note.

“(2) Gifts accepted under paragraph (1) shall be available for obligation or other use by the United States only to the extent and in the amounts provided in appropriation Acts.”.

(b) **EFFECTIVE DATE.**—The amendments made by subsection (a) shall be effective for fiscal years beginning after September 30, 1989.

SEC. 5057. TECHNICAL AMENDMENT TO NATIONAL COMMISSION ON CHILDREN.

Section 1139(d) (42 U.S.C. 1320b-9(d)) is amended in the matter preceding paragraph (1), by striking “an interim report no later than March 31, 1991, and a final report no later than September 30, 1990” and inserting “an interim report no later than September 30, 1990, and a final report no later than March 31, 1991”.

SEC. 5058. EXTENSION OF PROHIBITION AGAINST IMPLEMENTATION OF PROPOSED REGULATIONS ON EMERGENCY ASSISTANCE AND AFDC SPECIAL NEEDS.

Section 8005 of the Omnibus Budget Reconciliation Act of 1989 (42 U.S.C. 606 note) is amended in each of subsections (a)(2) and (c) by striking “1990” and inserting “1991”.

SEC. 5059. AMENDMENTS TO MINNESOTA FAMILY INVESTMENT PLAN DEMONSTRATION.

Section 8015 of the Omnibus Budget Reconciliation Act of 1989 (42 U.S.C. 602 note) is amended—

(1) in subsection (a), by striking “part A” and inserting “parts A and F”;

(2) in subsection (b)(3), by striking “(e)” and inserting “(d)”;

(3) in subsection (b)(6), by inserting “or that is assigned to and found eligible for the project” after “in the project”;

(4) in subsection (b)(8)(B)(ii), by inserting “(except that the age of the youngest child may be age 1 under the project even if the State plan specifies age 3)” after “such compliance”;

(5) in subsection (b)(8)(B)(ii)(I), by inserting “and” after the semicolon;

(6) in subsection (b)(8)(B)(ii), by striking “; and” after “age of 1 year” and all that follows through the end of subclause (III) and inserting “(except that, in a 2-parent family, this clause applies only to 1 parent).”;

(7) by amending subsection (b)(9) to read as follows:

“(9) **AVAILABILITY OF EDUCATION, EMPLOYMENT, AND TRAINING SERVICES.**—The State will make available education, employment, and training services equivalent to those services available under the State plan approved under part F of title IV of the Social Security Act to families required to enter into and comply with a contract with a county agency under the 1989 Minnesota Laws, section 10 of article 5 of chapter 282.”;

(8) in subsection (b)(10)(A)—

(A) by inserting “, except when a sanction is implemented under the 1989 Minnesota Laws, subdivision 3 of section 10 of article 5 of chapter 282,” after “ensure that”; and

(B) by striking “cash”;

(9) in subsection (b), by adding at the end the following:

“(12) **LIABILITY FOR COSTS.**—For each fiscal year, the Secretary shall not be liable for any costs related to carrying out the project in excess of those that the Secretary would have been

liable for had the project not been implemented, except for costs for evaluating the project.”;

(10) in subsection (c)(1)(B), by striking “50” and inserting “25”;

(11) in subsection (c)(2), by striking “part A” and inserting “parts A and F”;

(12) in subsection (d)(1)(B)(ii)—

(A) by inserting “except when a sanction is implemented under the 1989 Minnesota Laws, subdivision 3 of section 10 of article 5 of chapter 282,” before “permit”; and

(B) by striking “cash”;

(13) in subsection (d)(1)(B)(iii), by striking “section 402(a)(19)(C) of such Act” and inserting “subparagraph (C), (D), or (E) of section 402(a)(19) of such Act (except that the exemption for a parent with a child under 1 year of age need not be specified in the State plan)”;

(14) by adding at the end the following:

“(i) CONSTRUCTION.—For purposes of any Federal, State, or local law other than part A of title IV of the Social Security Act, the Food Stamp Act of 1977, or this section—

“(1) families participating in the project shall be considered to be recipients of aid under such part; and

“(2) cash assistance provided under the project to any such family and not designated by the State as food assistance shall be treated as if such assistance were aid received under such part.”.

SEC. 5060. GOOD CAUSE EXCEPTION TO REQUIRED COOPERATION FOR TRANSITIONAL CHILD CARE BENEFITS.

(a) IN GENERAL.—Section 402(g)(1)(A)(vi)(II) (42 U.S.C. 602(g)(1)(A)(vi)(II)) is amended to read as follows:

“(II) refused to cooperate with the State in establishing and enforcing his or her child support obligations, without good cause as determined by the State agency in accordance with standards prescribed by the Secretary which shall take into consideration the best interests of the child for whom child care is to be provided.”.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date of the enactment of this Act.

42 USC 602 note.

SEC. 5061. TECHNICAL CORRECTIONS REGARDING PENALTY FOR FAILURE TO PARTICIPATE IN JOBS PROGRAM.

(a) IN GENERAL.—Section 407(b)(1)(B) (42 U.S.C. 607(b)(1)(B)))⁵⁷ is amended—

(1) in clause (iii)—

(A) by striking “—” and all that follows through “(II)”;

and

(B) by striking “and ” at the end;

(2) in clause (iv), by striking the period and inserting “; and”;

and

(3) by adding at the end the following:

“(v) that, if and for so long as the child’s parent described in subparagraph (A)(i), unless meeting a condition of section 402(a)(19)(C), is, without good cause, not participating (or available for participation) in a program under part F, or if exempt under such section by reason of clause (vii) thereof or because there has not been established or provided under part F a program in which such parent can effectively participate, is not registered with the public employment

⁵⁷ So in original. Probably should be “607(b)(1)(B))”.

offices in the State, the needs of such parent shall not be taken into account in determining the need of such parent's family under section 402(a)(7), and the needs of such parent's spouse shall not be so taken into account unless such spouse is participating in such a program, or if not participating solely by reason of section 402(a)(19)(C)(vii) or because there has not been established or provided under part F a program in which such spouse can effectively participate, is registered with the public employment offices of the State; and if neither parents' needs are so taken into account, the payment provisions of section 402(a)(19)(G)(i)(I) shall apply."

42 USC 607 note.

(b) **EFFECTIVE DATE.**—The amendments made by subsection (a) shall take effect at the same time and in the same manner as the amendments made by title II of the Family Support Act of 1988 take effect.

SEC. 5062. TECHNICAL CORRECTIONS REGARDING AFDC-UP ELIGIBILITY REQUIREMENTS.

(a) **IN GENERAL.**—Section 407(d)(1) (42 U.S.C. 607(d)(1)) is amended—

(1) by striking "a calendar quarter (A)" and inserting "(A) a calendar quarter";

(2) by striking "or" at the end of subparagraph (A); and

(3) by inserting ", and (C) a calendar quarter ending before October 1990 in which such individual participated in a community work experience program under section 409 (as in effect for a State immediately before the effective date for that State of the amendments made by title II of the Family Support Act of 1988) or the work incentive program established under part C (as in effect for a State immediately before such effective date)" before the semicolon.

42 USC 607 note.

(b) **EFFECTIVE DATE.**—The amendments made by subsection (a) shall take effect on the date of the enactment of this Act.

SEC. 5063. FAMILY SUPPORT ACT DEMONSTRATION PROJECTS.

42 USC 1315
note.

Section 505 of the Family Support Act of 1988 (42 U.S.C. 1315; P.L. 100-385) is amended—

(1) in subsection (a), by inserting "in each of the fiscal years 1990, 1991, and 1992," before "shall"; and

(2) in subsection (e), by striking "September 30, 1989" and inserting "September 30 of the fiscal year specified in the agreement described in subsection (a)"

SEC. 5064. STUDY OF JOBS PROGRAMS OPERATED BY INDIAN TRIBES AND ALASKA NATIVE ORGANIZATIONS.

(a) **IN GENERAL.**—Within 180 days after the date of the enactment of this Act, the Comptroller General of the United States (in this section referred to as the "Comptroller") shall conduct a study of the implementation of section 482(i) of the Social Security Act (42 U.S.C. 682(i)) relating to job opportunities and basic skills training programs (in this section referred to as "JOBS programs") operated by Indian tribes and Alaska Native organizations (as defined in paragraph (5) of such section 482(i)).

(b) **REQUIREMENTS FOR STUDY.**—In conducting the study described in subsection (a), the Comptroller shall—

(1) identify any problems associated with the implementation of section 482(i) of the Social Security Act; and

(2) assess (to the extent practicable) the effectiveness of the JOBS programs operated by Indian tribes and Alaska Native organizations.

(c) **REPORT.**—Upon completion of the study described in subsection (a), the Comptroller shall submit a report to the appropriate committees of the Congress that includes—

(1) a summary of the findings of the study; and

(2) recommendations with respect to proposed legislation or changes in administrative policy to improve the effectiveness of JOBS programs conducted pursuant to section 482(i) of the Social Security Act.

CHAPTER 5—CHILD WELFARE AND FOSTER CARE

SEC. 5071. ACCOUNTING FOR ADMINISTRATIVE COSTS.

(a) **RECLASSIFICATION.**—Section 474(a)(3) (42 U.S.C. 674(a)(3)) is amended by inserting “provision of child placement services and for the” before “proper and efficient”.

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall take effect on the date of the enactment of this Act. 42 USC 674 note.

SEC. 5072. SECTION 427 TRIENNIAL REVIEWS.

(a) **AMENDMENTS TO SECTION 10406 OF OBRA 1989.**—Section 10406 of the Omnibus Budget Reconciliation Act of 1989 (42 U.S.C. 627 note) is amended—

(1) by striking “1991” and inserting “1992”;

(2) by striking “1990” and inserting “1991”; and

(3) in the section heading, by striking “1990” and inserting “1991”.

(b) **CONFORMING AMENDMENT.**—The item relating to section 10406 in the table of contents appearing immediately after section 10000 of such Act is amended by striking “1990” and inserting “1991”

SEC. 5073. INDEPENDENT LIVING INITIATIVES.

(a) **IN GENERAL.**—Section 477(a)(2)(C) (42 U.S.C. 677(a)(2)(C)) is amended—

(1) by inserting “who has not attained age 21” after “may at the option of the State also include any child”; and

(2) by striking “, but such child” and all that follows through “care”.

(b) **EFFECTIVE DATE.**—The amendments made by subsection (a) shall apply to payments made under part E of title IV of the Social Security Act for fiscal years beginning in or after fiscal year 1991. 42 USC 677 note.

CHAPTER 6—CHILD CARE

SEC. 5081. GRANTS TO STATES FOR CHILD CARE.

(a) **RULES GOVERNING PROVISION OF CHILD CARE TO ELIGIBLE FAMILIES.**—Section 402 (42 U.S.C. 602) is amended by adding at the end the following:

“(i)(1) Each State agency may, to the extent that it determines that resources are available, provide child care in accordance with paragraph (2) to any low income family that the State determines—

“(A) is not receiving aid under the State plan approved under this part;

“(B) needs such care in order to work; and

“(C) would be at risk of becoming eligible for aid under the State plan approved under this part if such care were not provided.

“(2) The State agency may provide child care pursuant to paragraph (1) by—

“(A) providing such care directly;

“(B) arranging such care through providers by use of purchase of service contracts or vouchers;

“(C) providing cash or vouchers in advance to the family;

“(D) reimbursing the family; or

“(E) adopting such other arrangements as the agency deems appropriate.

“(3)(A) A family provided with child care under paragraph (1) shall contribute to such care in accordance with a sliding scale formula established by the State agency based on the family’s ability to pay.

“(B) The State agency shall make payment for the cost of child care provided under paragraph (1) with respect to a family in an amount that is the lesser of—

“(i) the actual cost of such care; and

“(ii) the applicable local market rate (as determined by the State in accordance with regulations issued by the Secretary).

“(4) The value of any child care provided or arranged (or any amount received as payment for such care or reimbursement for costs incurred for the care) under this subsection—

“(A) shall not be treated as income or as a deductible expense for purposes of any other Federal or federally assisted program that bases eligibility for or amount of benefits upon need; and

“(B) may not be claimed as an employment-related expense for purposes of the credit under section 21 of the Internal Revenue Code of 1986.

“(5) Amounts expended by the State agency for child care under paragraph (1) shall be treated as amounts for which payment may be made to a State under section 403(n) only to the extent that—

“(A) such amounts are paid in accordance with paragraph (3)(B);

“(B) the care involved meets applicable standards of State and local law;

“(C) the provider of the care—

“(i) in the case of a provider who is not an individual that provides such care solely to members of the family of the individual, is licensed, regulated, or registered by the State or locality in which the care is provided; and

“(ii) allows parental access; and

“(D) such amounts are not used to supplant any other Federal or State funds used for child care services.

“(6)(A)(i) Each State shall prepare reports annually, beginning with fiscal year 1993, on the activities of the State carried out with funds made available under section 403(n).

“(ii) The State shall make available for public inspection within the State copies of each report required by this paragraph, shall transmit a copy of each such report to the Secretary, and shall provide a copy of each such report, on request, to any interested public agency.

“(iii) The Secretary shall annually compile, and submit to the Congress, the State reports transmitted to the Secretary pursuant to clause (ii).

“(B) Each report prepared and transmitted by a State under subparagraph (A) shall set forth with respect to child care services provided under this subsection—

“(i) showing separately for center-based child care services, group home child care services, family child care services, and relative care services, the number of children who received such services and the average cost of such services;

“(ii) the criteria applied in determining eligibility or priority for receiving services, and sliding fee schedules;

“(iii) the child care licensing and regulatory (including registration) requirements in effect in the State with respect to each type of service specified in clause (i); and

“(iv) the enforcement policies and practices in effect in the State which apply to licensed and regulated child care providers (including providers required to register).

“(C) Within 12 months after the date of the enactment of this subsection, the Secretary shall establish uniform reporting requirements for use by the States in preparing the information required by this paragraph, and make such other provision as may be necessary or appropriate to ensure that compliance with this subsection will not be unduly burdensome on the States.

“(D) Not later than July 1, 1992, the Secretary shall issue a report on the implementation of this subsection, based on such information as as has⁵⁸ been made available to the Secretary by the States.”.

(b) PAYMENTS TO STATES.—Section 403 (42 U.S.C. 603) is amended by adding at the end the following:

“(n)(1) In addition to any payment under subsection (a) or (l), each State shall be entitled to payment from the Secretary of an amount equal to the lesser of—

“(A) the Federal medical assistance percentage (as defined in section 1905(b)) of the expenditures by the State in providing child care services pursuant to section 402(i), and in administering the provision of such child care services, for any fiscal year; and

“(B) the limitation determined under paragraph (2) with respect to the State for the fiscal year.

“(2)(A) The limitation determined under this paragraph with respect to a State for any fiscal year is the amount that bears the same ratio to the amount specified in subparagraph (B) for such fiscal year as the number of children residing in the State in the second preceding fiscal year bears to the number of children residing in the United States in the second preceding fiscal year.

“(B) The amount specified in this subparagraph is—

“(i) \$300,000,000 for fiscal year 1991;

“(ii) \$300,000,000 for fiscal year 1992;

“(iii) \$300,000,000 for fiscal year 1993;

“(iv) \$300,000,000 for fiscal year 1994; and

“(v) \$300,000,000 for fiscal year 1995, and for each fiscal year thereafter.

“(C) If the limitation determined under subparagraph (A) with respect to a State for a fiscal year exceeds the amount paid to the State under this subsection for the fiscal year, the limitation determined under this paragraph with respect to the State for the

⁵⁸ So in original. Probably should be “information as has”.

immediately succeeding fiscal year shall be increased by the amount of such excess.

“(3) Amounts appropriated for a fiscal year to carry out this part shall be made available for payments under this subsection for such fiscal year.”

(c) AMENDMENTS TO GRANTS TO STATES TO IMPROVE CHILD CARE LICENSING AND REGISTRATION REQUIREMENTS, AND TO MONITOR CHILD CARE PROVIDED TO CHILDREN RECEIVING AFDC.—

(1) GRANTS INCREASED AND EXTENDED.—Section 402(g)(6)(D) (42 U.S.C. 602(g)(6)(D)) is amended by inserting “, and \$50,000,000 for each of fiscal years 1992, 1993, and 1994” before the period.

(2) NEW PURPOSES FOR GRANTS.—Section 402(g)(6)(A) (42 U.S.C. 602(g)(6)(A)) is amended by striking “and to monitor child care provided to children receiving aid under the State plan approved under subsection (a)” and inserting “to enforce standards with respect to child care provided to children under this part, and to provide for the training of child care providers”.

(3) HALF OF GRANT REQUIRED TO BE EXPENDED FOR TRAINING OF CHILD CARE PROVIDERS.—Section 402(g)(6) (42 U.S.C. 602(g)(6)) is amended by adding at the end the following:

“(E) Each State to which the Secretary makes a grant under this paragraph shall expend not less than 50 percent of the amount of the grant to provide for the training of child care providers.”.

(d) COORDINATION WITH OTHER PROGRAMS FOR CHILDREN.—Section 402(g)(7) (42 U.S.C. 602(g)(7)) is amended by inserting “and subsection (i)” after “this subsection”.

42 USC 602 note.

(e) EFFECTIVE DATE.—Except as otherwise expressly provided, the amendments made by this section shall take effect on October 1, 1990.

SEC. 5082. CHILD CARE AND DEVELOPMENT BLOCK GRANT.

Chapter 8 of subtitle A of title IV of the Omnibus Budget Reconciliation Act of 1981 (Public Law 97-35) is amended—

(1) by redesignating subchapters C, D, and E, as subchapters D, E, and F, respectively; and

(2) by inserting after subchapter B the following new subchapter:

“Subchapter C—Child Care and Development Block Grant

Child Care and Development Block Grant Act of 1990.
42 USC 9801 note.

“SEC. 658A. SHORT TITLE.

“This subchapter may be cited as the ‘Child Care and Development Block Grant Act of 1990’.

42 USC 9858.

“SEC. 658B. AUTHORIZATION OF APPROPRIATIONS.

“There are authorized to be appropriated to carry out this subchapter, \$750,000,000 for fiscal year 1991, \$825,000,000 for fiscal year 1992, \$925,000,000 for fiscal year 1993, and such sums as may be necessary for each of the fiscal years 1994 and 1995.

42 USC 9858a.

“SEC. 658C. ESTABLISHMENT OF BLOCK GRANT PROGRAM.

“The Secretary is authorized to make grants to States in accordance with the provisions of this subchapter.

42 USC 9858b.

“SEC. 658D. LEAD AGENCY.

“(a) DESIGNATION.—The chief executive officer of a State desiring to receive a grant under this subchapter shall designate, in an

application submitted to the Secretary under section 658E, an appropriate State agency that complies with the requirements of subsection (b) to act as the lead agency.

“(b) DUTIES.—

“(1) IN GENERAL.—The lead agency shall—

“(A) administer, directly or through other State agencies, the financial assistance received under this subchapter by the State;

“(B) develop the State plan to be submitted to the Secretary under section 658E(a);

“(C) in conjunction with the development of the State plan as required under subparagraph (B), hold at least one hearing in the State to provide to the public an opportunity to comment on the provision of child care services under the State plan; and

“(D) coordinate the provision of services under this subchapter with other Federal, State and local child care and early childhood development programs.

“(2) DEVELOPMENT OF PLAN.—In the development of the State plan described in paragraph (1)(B), the lead agency shall consult with appropriate representatives of units of general purpose local government. Such consultations may include consideration of local child care needs and resources, the effectiveness of existing child care and early childhood development services, and the methods by which funds made available under this subchapter can be used to effectively address local shortages.

“SEC. 658E. APPLICATION AND PLAN.

42 USC 9858c.

“(a) APPLICATION.—To be eligible to receive assistance under this subchapter, a State shall prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary shall by rule require, including—

“(1) an assurance that the State will comply with the requirements of this subchapter; and

“(2) a State plan that meets the requirements of subsection (c).

“(b) PERIOD COVERED BY PLAN.—The State plan contained in the application under subsection (a) shall be designed to be implemented—

“(1) during a 3-year period for the initial State plan; and

“(2) during a 2-year period for subsequent State plans.

“(c) REQUIREMENTS OF A PLAN.—

“(1) LEAD AGENCY.—The State plan shall identify the lead agency designated under section 658D.

“(2) POLICIES AND PROCEDURES.—The State plan shall:

“(A) PARENTAL CHOICE OF PROVIDERS.—Provide assurances that—

“(i) the parent or parents of each eligible child within the State who receives or is offered child care services for which financial assistance is provided under this subchapter, other than through assistance provided under paragraph (3)(C), are given the option either—

“(I) to enroll such child with a child care provider that has a grant or contract for the provision of such services; or

“(II) to receive a child care certificate as defined in section 658P(2);

“(ii) in cases in which the parent selects the option described in clause (i)(I), the child will be enrolled with the eligible provider selected by the parent to the maximum extent practicable; and

“(iii) child care certificates offered to parents selecting the option described in clause (i)(II) shall be of a value commensurate with the subsidy value of child care services provided under the option described in clause (i)(I);

except that nothing in this subparagraph shall require a State to have a child care certificate program in operation prior to October 1, 1992.

“(B) UNLIMITED PARENTAL ACCESS.—Provide assurances that procedures are in effect within the State to ensure that child care providers who provide services for which assistance is made available under this subchapter afford parents unlimited access to their children and to the providers caring for their children, during the normal hours of operation of such providers and whenever such children are in the care of such providers.

“(C) PARENTAL COMPLAINTS.—Provide assurances that the State maintains a record of substantiated parental complaints and makes information regarding such parental complaints available to the public on request.

“(D) CONSUMER EDUCATION.—Provide assurances that consumer education information will be made available to parents and the general public within the State concerning licensing and regulatory requirements, complaint procedures, and policies and practices relative to child care services within the State.

“(E) COMPLIANCE WITH STATE AND LOCAL REGULATORY REQUIREMENTS.—Provide assurances that—

“(i) all providers of child care services within the State for which assistance is provided under this subchapter comply with all licensing or regulatory requirements (including registration requirements) applicable under State and local law; and

“(ii) providers within the State that are not required to be licensed or regulated under State or local law are required to be registered with the State prior to payment being made under this subchapter, in accordance with procedures designed to facilitate appropriate payment to such providers, and to permit the State to furnish information to such providers, including information on the availability of health and safety training, technical assistance, and any relevant information pertaining to regulatory requirements in the State, and that such providers shall be permitted to register with the State after selection by the parents of eligible children and before such payment is made.

This subparagraph shall not be construed to prohibit a State from imposing more stringent standards and licensing or regulatory requirements on child care providers within the State that provide services for which assistance is provided under this subchapter than the standards or requirements imposed on other child care providers in the State.

“(F) ESTABLISHMENT OF HEALTH AND SAFETY REQUIREMENTS.—Provide assurances that there are in effect within the State, under State or local law, requirements designed to protect the health and safety of children that are applicable to child care providers that provide services for which assistance is made available under this subchapter. Such requirements shall include—

“(i) the prevention and control of infectious diseases (including immunization);

“(ii) building and physical premises safety; and

“(iii) minimum health and safety training appropriate to the provider setting.

Nothing in this subparagraph shall be construed to require the establishment of additional health and safety requirements for child care providers that are subject to health and safety requirements in the categories described in this subparagraph on the date of enactment of this subchapter under State or local law.

“(G) COMPLIANCE WITH STATE AND LOCAL HEALTH AND SAFETY REQUIREMENTS.—Provide assurances that procedures are in effect to ensure that child care providers within the State that provide services for which assistance is provided under this subchapter comply with all applicable State or local health and safety requirements as described in subparagraph (F).

“(H) REDUCTION IN STANDARDS.—Provide assurances that if the State reduces the level of standards applicable to child care services provided in the State on the date of enactment of this subchapter, the State shall inform the Secretary of the rationale for such reduction in the annual report of the State described in section 658K.

“(I) REVIEW OF STATE LICENSING AND REGULATORY REQUIREMENTS.—Provide assurances that not later than 18 months after the date of the submission of the application under section 658E, the State will complete a full review of the law applicable to, and the licensing and regulatory requirements and policies of, each licensing agency that regulates child care services and programs in the State unless the State has reviewed such law, requirements, and policies in the 3-year period ending on the date of the enactment of this subchapter.

“(J) SUPPLEMENTATION.—Provide assurances that funds received under this subchapter by the State will be used only to supplement, not to supplant, the amount of Federal, State, and local funds otherwise expended for the support of child care services and related programs in the State.

“(3) USE OF BLOCK GRANT FUNDS.—

“(A) GENERAL REQUIREMENT.—The State plan shall provide that the State will use the amounts provided to the State for each fiscal year under this subchapter as required under subparagraphs (B) and (C).

“(B) CHILD CARE SERVICES.—Subject to the reservation contained in subparagraph (C), the State shall use amounts provided to the State for each fiscal year under this subchapter for—

“(i) child care services, that meet the requirements of this subchapter, that are provided to eligible children

in the State on a sliding fee scale basis using funding methods provided for in section 658E(c)(2)(A), with priority being given for services provided to children of families with very low family incomes (taking into consideration family size) and to children with special needs; and

“(ii) activities designed to improve the availability and quality of child care.

“(C) ACTIVITIES TO IMPROVE THE QUALITY OF CHILD CARE AND TO INCREASE THE AVAILABILITY OF EARLY CHILDHOOD DEVELOPMENT AND BEFORE- AND AFTER-SCHOOL CARE SERVICES.—The State shall reserve 25 percent of the amounts provided to the State for each fiscal year under this subchapter to carry out activities designed to improve the quality of child care (as described in section 658G) and to provide before- and after-school and early childhood development services (as described in section 658H).

“(4) PAYMENT RATES.—

“(A) IN GENERAL.—The State plan shall provide assurances that payment rates for the provision of child care services for which assistance is provided under this subchapter are sufficient to ensure equal access for eligible children to comparable child care services in the State or substate area that are provided to children whose parents are not eligible to receive assistance under this subchapter or for child care assistance under any other Federal or State programs. Such payment rates shall take into account the variations in the costs of providing child care in different settings and to children of different age groups, and the additional costs of providing child care for children with special needs.

“(B) CONSTRUCTION.—Nothing in this paragraph shall be construed to create a private right of action.

“(5) SLIDING FEE SCALE.—The State plan shall provide that the State will establish and periodically revise, by rule, a sliding fee scale that provides for cost sharing by the families that receive child care services for which assistance is provided under this subchapter.

“(d) APPROVAL OF APPLICATION.—The Secretary shall approve an application that satisfies the requirements of this section.

42 USC 9858d.

SEC. 658F.⁵⁹ LIMITATIONS ON STATE ALLOTMENTS.

“(a) NO ENTITLEMENT TO CONTRACT OR GRANT.—Nothing in this subchapter shall be construed—

“(1) to entitle any child care provider or recipient of a child care certificate to any contract, grant or benefit; or

“(2) to limit the right of any State to impose additional limitations or conditions on contracts or grants funded under this subchapter.

“(b) CONSTRUCTION OF FACILITIES.—

“(1) IN GENERAL.—No funds made available under this subchapter shall be expended for the purchase or improvement of land, or for the purchase, construction, or permanent improvement (other than minor remodeling) of any building or facility.

“(2) SECTARIAN AGENCY OR ORGANIZATION.—In the case of a sectarian agency or organization, no funds made available under this subchapter may be used for the purposes described in

⁵⁹ So in original. Probably should be “ “SEC. 658F.”.

paragraph (1) except to the extent that renovation or repair is necessary to bring the facility of such agency or organization into compliance with health and safety requirements referred to in section 658E(c)(2)(F).

“SEC. 658G. ACTIVITIES TO IMPROVE THE QUALITY OF CHILD CARE.

42 USC 9858e.

“A State that receives financial assistance under this subchapter shall use not less than 20 percent of the amounts reserved by such State under section 658E(c)(3)(C) for each fiscal year for one or more of the following:

“(1) **RESOURCE AND REFERRAL PROGRAMS.**—Operating directly or providing financial assistance to private nonprofit organizations or public organizations (including units of general purpose local government) for the development, establishment, expansion, operation, and coordination of resource and referral programs specifically related to child care.

“(2) **GRANTS OR LOANS TO ASSIST IN MEETING STATE AND LOCAL STANDARDS.**—Making grants or providing loans to child care providers to assist such providers in meeting applicable State and local child care standards.

“(3) **MONITORING OF COMPLIANCE WITH LICENSING AND REGULATORY REQUIREMENTS.**—Improving the monitoring of compliance with, and enforcement of, State and local licensing and regulatory requirements (including registration requirements).

“(4) **TRAINING.**—Providing training and technical assistance in areas appropriate to the provision of child care services, such as training in health and safety, nutrition, first aid, the recognition of communicable diseases, child abuse detection and prevention, and the care of children with special needs.

“(5) **COMPENSATION.**—Improving salaries and other compensation paid to full- and part-time staff who provide child care services for which assistance is provided under this subchapter.

“SEC. 658H. EARLY CHILDHOOD DEVELOPMENT AND BEFORE- AND AFTER-SCHOOL SERVICES.

42 USC 9858f.

“(a) **IN GENERAL.**—A State that receives financial assistance under this subchapter shall use not less than 75 percent of the amounts reserved by such State under section 658E(c)(3)(C) for each fiscal year to establish or expand and conduct, through the provision of grants or contracts, early childhood development or before- and after-school child care programs, or both.

“(b) **PROGRAM DESCRIPTION.**—Programs that receive assistance under this section shall—

“(1) in the case of early childhood development programs, consist of services that are not intended to serve as a substitute for a compulsory academic programs but that are intended to provide an environment that enhances the educational, social, cultural, emotional, and recreational development of children; and

“(2) in the case of before- and after-school child care programs—

“(A) be provided Monday through Friday, including school holidays and vacation periods other than legal public holidays, to children attending early childhood development programs, kindergarten, or elementary or secondary school classes during such times of the day and on such

days that regular instructional services are not in session;
and

“(B) not be intended to extend or replace the regular academic program.

“(c) **PRIORITY FOR ASSISTANCE.**—In awarding grants and contracts under this section, the State shall give the highest priority to geographic areas within the State that are eligible to receive grants under section 1006 of the Elementary and Secondary Education Act of 1965, and shall then give priority to—

“(1) any other areas with concentrations of poverty; and

“(2) any areas with very high or very low population densities.

42 USC 9858g.

“**SEC. 658I. ADMINISTRATION AND ENFORCEMENT.**

“(a) **ADMINISTRATION.**—The Secretary shall—

“(1) coordinate all activities of the Department of Health and Human Services relating to child care, and, to the maximum extent practicable, coordinate such activities with similar activities of other Federal entities;

“(2) collect, publish and make available to the public a listing of State child care standards at least once every 3 years; and

“(3) provide technical assistance to assist States to carry out this subchapter, including assistance on a reimbursable basis.

“(b) **ENFORCEMENT.**—

“(1) **REVIEW OF COMPLIANCE WITH STATE PLAN.**—The Secretary shall review and monitor State compliance with this subchapter and the plan approved under section 658E(c) for the State, and shall have the power to terminate payments to the State in accordance with paragraph (2).

“(2) **NONCOMPLIANCE.**—

“(A) **IN GENERAL.**—If the Secretary, after reasonable notice to a State and opportunity for a hearing, finds that—

“(i) there has been a failure by the State to comply substantially with any provision or requirement set forth in the plan approved under section 658E(c) for the State; or

“(ii) in the operation of any program for which assistance is provided under this subchapter there is a failure by the State to comply substantially with any provision of this subchapter;

the Secretary shall notify the State of the finding and that no further payments may be made to such State under this subchapter (or, in the case of noncompliance in the operation of a program or activity, that no further payments to the State will be made with respect to such program or activity) until the Secretary is satisfied that there is no longer any such failure to comply or that the noncompliance will be promptly corrected.

“(B) **ADDITIONAL SANCTIONS.**—In the case of a finding of noncompliance made pursuant to subparagraph (A), the Secretary may, in addition to imposing the sanctions described in such subparagraph, impose other appropriate sanctions, including recoupment of money improperly expended for purposes prohibited or not authorized by this subchapter, and disqualification from the receipt of financial assistance under this subchapter.

“(C) NOTICE.—The notice required under subparagraph (A) shall include a specific identification of any additional sanction being imposed under subparagraph (B).

“(3) ISSUANCE OF RULES.—The Secretary shall establish by rule procedures for—

“(A) receiving, processing, and determining the validity of complaints concerning any failure of a State to comply with the State plan or any requirement of this subchapter; and

“(B) imposing sanctions under this section.

“SEC. 658J. PAYMENTS.

42 USC 9858h.

“(a) IN GENERAL.—Subject to the availability of appropriations, a State that has an application approved by the Secretary under section 658E(d) shall be entitled to a payment under this section for each fiscal year in an amount equal to its allotment under section 658O for such fiscal year.

“(b) METHOD OF PAYMENT.—

“(1) IN GENERAL.—Subject to paragraph (2), the Secretary may make payments to a State in installments, and in advance or by way of reimbursement, with necessary adjustments on account of overpayments or underpayments, as the Secretary may determine.

“(2) LIMITATION.—The Secretary may not make such payments in a manner that prevents the State from complying with the requirement specified in section 658E(c)(3).

“(c) SPENDING OF FUNDS BY STATE.—Payments to a State from the allotment under section 658O for any fiscal year may be expended by the State in that fiscal year or in the succeeding fiscal year.

“SEC. 658K. ANNUAL REPORT AND AUDITS.

42 USC 9858i.

“(a) ANNUAL REPORT.—Not later than December 31, 1992, and annually thereafter, a State that receives assistance under this subchapter shall prepare and submit to the Secretary a report—

“(1) specifying the uses for which the State expended funds specified under paragraph (3) of section 658E(c) and the amount of funds expended for such uses;

“(2) containing available data on the manner in which the child care needs of families in the State are being fulfilled, including information concerning—

“(A) the number of children being assisted with funds provided under this subchapter, and under other Federal child care and pre-school programs;

“(B) the type and number of child care programs, child care providers, caregivers, and support personnel located in the State;

“(C) salaries and other compensation paid to full- and part-time staff who provide child care services; and

“(D) activities in the State to encourage public-private partnerships that promote business involvement in meeting child care needs;

“(3) describing the extent to which the affordability and availability of child care services has increased;

“(4) if applicable, describing, in either the first or second such report, the findings of the review of State licensing and regulatory requirements and policies described in section 658E(c), including a description of actions taken by the State in response to such reviews;

“(5) containing an explanation of any State action, in accordance with section 658E, to reduce the level of child care standards in the State, if applicable; and

“(6) describing the standards and health and safety requirements applicable to child care providers in the State, including a description of State efforts to improve the quality of child care;

during the period for which such report is required to be submitted.

“(b) AUDITS.—

“(1) REQUIREMENT.—A State shall, after the close of each program period covered by a ⁶⁰ application approved under section 658E(d) audit its expenditures during such program period from amounts received under this subchapter.

“(2) INDEPENDENT AUDITOR.—Audits under this subsection shall be conducted by an entity that is independent of any agency administering activities that receive assistance under this subchapter and be in accordance with generally accepted auditing principles.

“(3) SUBMISSION.—Not later than 30 days after the completion of an audit under this subsection, the State shall submit a copy of the audit to the legislature of the State and to the Secretary.

“(4) REPAYMENT OF AMOUNTS.—Each State shall repay to the United States any amounts determined through an audit under this subsection not to have been expended in accordance with this subchapter, or the Secretary may offset such amounts against any other amount to which the State is or may be entitled under this subchapter.

42 USC 9858j.

“SEC. 658L. REPORT BY SECRETARY.

“Not later than July 31, 1993, and annually thereafter, the Secretary shall prepare and submit to the Committee on Education and Labor of the House of Representatives and the Committee on Labor and Human Resources of the Senate a report that contains a summary and analysis of the data and information provided to the Secretary in the State reports submitted under section 658K. Such report shall include an assessment, and where appropriate, recommendations for the Congress concerning efforts that should be undertaken to improve the access of the public to quality and affordable child care in the United States.

42 USC 9858k.

“SEC. 658M. LIMITATIONS ON USE OF FINANCIAL ASSISTANCE FOR CERTAIN PURPOSES.

“(a) SECTARIAN PURPOSES AND ACTIVITIES.—No financial assistance provided under this subchapter, pursuant to the choice of a parent under section 658E(c)(2)(A)(i)(I) or through any other grant or contract under the State plan, shall be expended for any sectarian purpose or activity, including sectarian worship or instruction.

“(b) TUITION.—With regard to services provided to students enrolled in grades 1 through 12, no financial assistance provided under this subchapter shall be expended for—

“(1) any services provided to such students during the regular school day;

“(2) any services for which such students receive academic credit toward graduation; or

“(3) any instructional services which supplant or duplicate the academic program of any public or private school.

⁶⁰ So in original. Probably should be “an”.

“SEC. 658N. NONDISCRIMINATION.

42 USC 9858l.

“(a) RELIGIOUS NONDISCRIMINATION.—

“(1) CONSTRUCTION.—

“(A) IN GENERAL.—Except as provided in subparagraph (B), nothing in this section shall be construed to modify or affect the provisions of any other Federal law or regulation that relates to discrimination in employment on the basis of religion.

“(B) EXCEPTION.—A sectarian organization may require that employees adhere to the religious tenets and teachings of such organization, and such organization may require that employees adhere to rules forbidding the use of drugs or alcohol.

“(2) DISCRIMINATION AGAINST CHILD.—

“(A) IN GENERAL.—A child care provider (other than a family child care provider) that receives assistance under this subchapter shall not discriminate against any child on the basis of religion in providing child care services.

“(B) NON-FUNDED CHILD CARE SLOTS.—Nothing in this section shall prohibit a child care provider from selecting children for child care slots that are not funded directly with assistance provided under this subchapter because such children or their family members participate on a regular basis in other activities of the organization that owns or operates such provider.

“(3) EMPLOYMENT IN GENERAL.—

“(A) PROHIBITION.—A child care provider that receives assistance under this subchapter shall not discriminate in employment on the basis of the religion of the prospective employee if such employee’s primary responsibility is or will be working directly with children in the provision of child care services.

“(B) QUALIFIED APPLICANTS.—If two or more prospective employees are qualified for any position with a child care provider receiving assistance under this subchapter, nothing in this section shall prohibit such child care provider from employing a prospective employee who is already participating on a regular basis in other activities of the organization that owns or operates such provider.

“(C) PRESENT EMPLOYEES.—This paragraph shall not apply to employees of child care providers receiving assistance under this subchapter if such employees are employed with the provider on the date of enactment of this subchapter.

“(4) EMPLOYMENT AND ADMISSION PRACTICES.—Notwithstanding paragraphs (1)(B), (2), and (3), if assistance provided under this subchapter, and any other Federal or State program, amounts to 80 percent or more of the operating budget of a child care provider that receives such assistance, the Secretary shall not permit such provider to receive any further assistance under this subchapter unless the grant or contract relating to the financial assistance, or the employment and admissions policies of the provider, specifically provides that no person with responsibilities in the operation of the child care program, project, or activity of the provider will discriminate against any individual in employment, if such employee’s primary respon-

sibility is or will be working directly with children in the provision of child care, or admissions because of the religion of such individual.

“(b) EFFECT ON STATE LAW.—Nothing in this subchapter shall be construed to supersede or modify any provision of a State constitution or State law that prohibits the expenditure of public funds in or by sectarian institutions, except that no provision of a State constitution or State law shall be construed to prohibit the expenditure in or by sectarian institutions of any Federal funds provided under this subchapter.

42 USC 9858m.

“SEC. 6580. AMOUNTS RESERVED; ALLOTMENTS.

“(a) AMOUNTS RESERVED.—

“(1) TERRITORIES AND POSSESSIONS.—The Secretary shall reserve not to exceed one half of 1 percent of the amount appropriated under this subchapter in each fiscal year for payments to Guam, American Samoa, the Virgin Islands of the United States, the Commonwealth of the Northern Mariana Islands, and the Trust Territory of the Pacific Islands to be allotted in accordance with their respective needs.

“(2) INDIANS TRIBES.—The Secretary shall reserve not more than 3 percent of the amount appropriated under section 658B in each fiscal year for payments to Indian tribes and tribal organizations with applications approved under subsection (c).

“(b) STATE ALLOTMENT.—

“(1) GENERAL RULE.—From the amounts appropriated under section 658B for each fiscal year remaining after reservations under subsection (a), the Secretary shall allot to each State an amount equal to the sum of—

“(A) an amount that bears the same ratio to 50 percent of such remainder as the product of the young child factor of the State and the allotment percentage of the State bears to the sum of the corresponding products for all States; and

“(B) an amount that bears the same ratio to 50 percent of such remainder as the product of the school lunch factor of the State and the allotment percentage of the State bears to the sum of the corresponding products for all States.

“(2) YOUNG CHILD FACTOR.—The term ‘young child factor’ means the ratio of the number of children in the State under 5 years of age to the number of such children in all States as provided by the most recent annual estimates of population in the States by the Census Bureau of the Department of Commerce.

“(3) SCHOOL LUNCH FACTOR.—The term ‘school lunch factor’ means the ratio of the number of children in the State who are receiving free or reduced price lunches under the school lunch program established under the National School Lunch Act (42 U.S.C. 1751 et seq.) to the number of such children in all the States as determined annually by the Department of Agriculture.

“(4) ALLOTMENT PERCENTAGE.—

“(A) IN GENERAL.—The allotment percentage for a State is determined by dividing the per capita income of all individuals in the United States, by the per capita income of all individuals in the State.

“(B) LIMITATIONS.—If an allotment percentage determined under subparagraph (A)—

“(i) exceeds 1.2 percent, then the allotment percentage of that State shall be considered to be 1.2 percent; and

“(ii) is less than 0.8 percent, then the allotment percentage of the State shall be considered to be 0.8 percent.

“(C) PER CAPITA INCOME.—For purposes of subparagraph (A), per capita income shall be—

“(i) determined at 2-year intervals;

“(ii) applied for the 2-year period beginning on October 1 of the first fiscal year beginning on the date such determination is made; and

“(iii) equal to the average of the annual per capita incomes for the most recent period of 3 consecutive years for which satisfactory data are available from the Department of Commerce at the time such determination is made.

“(c) PAYMENTS FOR THE BENEFIT OF INDIAN CHILDREN.—

“(1) GENERAL AUTHORITY.—From amounts reserved under subsection (a)(2), the Secretary may make grants to or enter into contracts with Indian tribes or tribal organizations that submit applications under this section, for the planning and carrying out of programs or activities consistent with the purposes of this subchapter.

“(2) APPLICATIONS AND REQUIREMENTS.—An application for a grant or contract under this section shall provide that:

“(A) COORDINATION.—The applicant will coordinate, to the maximum extent feasible, with the lead agency in the State or States in which the applicant will carry out programs or activities under this section.

“(B) SERVICES ON RESERVATIONS.—In the case of an applicant located in a State other than Alaska, California, or Oklahoma, programs and activities under this section will be carried out on the Indian reservation for the benefit of Indian children.

“(C) REPORTS AND AUDITS.—The applicant will make such reports on, and conduct such audits of, programs and activities under a grant or contract under this section as the Secretary may require.

“(3) CONSIDERATION OF SECRETARIAL APPROVAL.—In determining whether to approve an application for a grant or contract under this section, the Secretary shall take into consideration—

“(A) the availability of child care services provided in accordance with this subchapter by the State or States in which the applicant proposes to carry out a program to provide child care services; and

“(B) whether the applicant has the ability (including skills, personnel, resources, community support, and other necessary components) to satisfactorily carry out the proposed program or activity.

“(4) THREE-YEAR LIMIT.—Grants or contracts under this section shall be for periods not to exceed 3 years.

“(5) DUAL ELIGIBILITY OF INDIAN CHILDREN.—The awarding of a grant or contract under this section for programs or activities to be conducted in a State or States shall not affect the eligibility of any Indian child to receive services provided or to

participate in programs and activities carried out⁶¹ under a grant to the State or States under this subchapter.

“(d) DATA AND INFORMATION.—The Secretary shall obtain from each appropriate Federal agency, the most recent data and information necessary to determine the allotments provided for in subsection (b).

“(e) REALLOTMENTS.—

“(1) IN GENERAL.—Any portion of the allotment under subsection (b) to a State that the Secretary determines is not required to carry out a State plan approved under section 658E(d), in the period for which the allotment is made available, shall be reallocated by the Secretary to other States in proportion to the original allotments to the other States.

“(2) LIMITATIONS.—

“(A) REDUCTION.—The amount of any reallocation to which a State is entitled to under paragraph (1) shall be reduced to the extent that it exceeds the amount that the Secretary estimates will be used in the State to carry out a State plan approved under section 658E(d).

“(B) REALLOTMENTS.—The amount of such reduction shall be similarly reallocated among States for which no reduction in an allotment or reallocation is required by this subsection.

“(3) AMOUNTS REALLOCATED.—For purposes of any other section of this subchapter, any amount reallocated to a State under this subsection shall be considered to be part of the allotment made under subsection (b) to the State.

“(f) DEFINITION.—For the purposes of this section, the term ‘State’ includes only the 50 States, the District of Columbia, and the Commonwealth of Puerto Rico.

42 USC 9858n.

“SEC. 658P. DEFINITIONS.

“As used in this subchapter:

“(1) CAREGIVER.—The term ‘caregiver’ means an individual who provides a service directly to an eligible child on a person-to-person basis.

“(2) CHILD CARE CERTIFICATE.—The term ‘child care certificate’ means a certificate (that may be a check or other disbursement) that is issued by a State or local government under this subchapter directly to a parent who may use such certificate only as payment for child care services. Nothing in this subchapter shall preclude the use of such certificates for sectarian child care services if freely chosen by the parent. For purposes of this subchapter, child care certificates shall not be considered to be grants or contracts.

“(3) ELEMENTARY SCHOOL.—The term ‘elementary school’ means a day or residential school that provides elementary education, as determined under State law.

“(4) ELIGIBLE CHILD.—The term ‘eligible child’ means an individual—

“(A) who is less than 13 years of age;

“(B) whose family income does not exceed 75 percent of the State median income for a family of the same size; and

“(C) who—

“(i) resides with a parent or parents who are working or attending a job training or educational program; or

⁶¹ So in original. Probably should be “out”.

“(ii) is receiving, or needs to receive, protective services and resides with a parent or parents not described in clause (i).

“(5) **ELIGIBLE CHILD CARE PROVIDER.**—The term ‘eligible child care provider’ means—

“(A) a center-based child care provider, a group home child care provider, a family child care provider, or other provider of child care services for compensation that—

“(i) is licensed, regulated, or registered under State law as described in section 658E(c)(2)(E); and

“(ii) satisfies the State and local requirements, including those referred to in section 658E(c)(2)(F);

applicable to the child care services it provides; or

“(B) a child care provider that is 18 years of age or older who provides child care services only to eligible children who are, by affinity or consanguinity, or by court decree, the grandchild, niece, or nephew of such provider, if such provider is registered and complies with any State requirements that govern child care provided by the relative involved.

“(6) **FAMILY CHILD CARE PROVIDER.**—The term ‘family child care provider’ means one individual who provides child care services for fewer than 24 hours per day, as the sole caregiver, and in a private residence.

“(7) **INDIAN TRIBE.**—The term ‘Indian tribe’ has the meaning given it in section 4(b) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(b)).

“(8) **LEAD AGENCY.**—The term ‘lead agency’ means the agency designated under section 658B(a).

“(9) **PARENT.**—The term ‘parent’ includes a legal guardian or other person standing in loco parentis.

“(10) **SECONDARY SCHOOL.**—The term ‘secondary school’ means a day or residential school which provides secondary education, as determined under State law.

“(11) **SECRETARY.**—The term ‘Secretary’ means the Secretary of Health and Human Services unless the context specifies otherwise.

“(12) **SLIDING FEE SCALE.**—The term ‘sliding fee scale’ means a system of cost sharing by a family based on income and size of the family.

“(13) **STATE.**—The term ‘State’ means any of the several States, the District of Columbia, the Virgin Islands of the United States, the Commonwealth of Puerto Rico, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, and the Trust Territory of the Pacific Islands.

“(14) **TRIBAL ORGANIZATION.**—The term ‘tribal organization’ has the meaning given it in section 4(c) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(c)).

“**SEC. 658Q. PARENTAL RIGHTS AND RESPONSIBILITIES.**

42 USC 9858o.

“Nothing in this subchapter shall be construed or applied in any manner to infringe on or usurp the moral and legal rights and responsibilities of parents or legal guardians.

“**SEC. 658R. SEVERABILITY.**

42 USC 9858p.

“If any provision of this subchapter or the application thereof to any person or circumstance is held invalid, the invalidity shall not

affect other provisions of applications of this subchapter which can be given effect without regard to the invalid provision or application, and to this end the provisions of this subchapter shall be severable.”

SUBTITLE B—OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE

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SEC. 5101. AMENDMENT OF THE SOCIAL SECURITY ACT.

Except as otherwise expressly provided, whenever in this subtitle an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Social Security Act.

SEC. 5102. CONTINUATION OF DISABILITY BENEFITS DURING APPEAL.

- Subsection (g) of section 223 (42 U.S.C. 423(g)) is amended—
 - (1) in paragraph (1), in the matter following subparagraph (C), by inserting “or” after “hearing,” and by striking “pending, or (iii) June 1991.” and inserting “pending.”; and
 - (2) by striking paragraph (3).

SEC. 5103. REPEAL OF SPECIAL DISABILITY STANDARD FOR WIDOWS AND WIDOWERS.

(a) **IN GENERAL.**—Section 223(d)(2) (42 U.S.C. 423(d)(2)) is amended—

(1) in subparagraph (A), by striking “(except a widow, surviving divorced wife, widower, or surviving divorced husband for purposes of section 202(e) or (f))”;

(2) by striking subparagraph (B); and

(3) by redesignating subparagraph (C) as subparagraph (B).

(b) **CONFORMING AMENDMENTS.**—

(1) The third sentence of section 216(i)(1) (42 U.S.C. 416(i)(1)) is amended by striking “(2)(C)” and inserting “(2)(B)”.

(2) Section 223(f)(1)(B) (42 U.S.C. 423(f)(1)(B)) is amended to read as follows:

“(B) the individual is now able to engage in substantial gainful activity; or”.

(3) Section 223(f)(2)(A)(ii) (42 U.S.C. 423(f)(2)(A)(ii)) is amended to read as follows:

“(ii) the individual is now able to engage in substantial gainful activity, or”.

(4) Section 223(f)(3) (42 U.S.C. 423(f)(3)) is amended by striking “therefore—” and all that follows and inserting “therefore the individual is able to engage in substantial gainful activity; or”.

(5) Section 223(f) is further amended, in the matter following paragraph (4), by striking “(or gainful activity in the case of a widow, surviving divorced wife, widower, or surviving divorced husband)” each place it appears.

(c) **TRANSITIONAL RULES RELATING TO MEDICAID AND MEDICARE ELIGIBILITY.**—

(1) **DETERMINATION OF MEDICAID ELIGIBILITY.**—Section 1634(d) (42 U.S.C. 1383c(d)) is amended—

(A) by redesignating paragraphs (1) and (2) as subparagraphs (A) and (B), respectively;

(B) by striking “(d) If any person—” and inserting “(d)(1) This subsection applies with respect to any person who—”;

(C) in subparagraph (A) (as redesignated), by striking “as required” and all that follows through “but not entitled” and inserting “being then not entitled”;

(D) in subparagraph (B) (as redesignated), by striking “section 1616(a),” and inserting “section 1616(a) (or payments of the type described in section 212(a) of Public Law 93-66).”; and

(E) by striking “such person shall” and all that follows and inserting the following new paragraph:

“(2) For purposes of title XIX, each person with respect to whom this subsection applies—

“(A) shall be deemed to be a recipient of supplemental security income benefits under this title if such person received such a benefit for the month before the month in which such person began to receive a benefit described in paragraph (1)(A), and

“(B) shall be deemed to be a recipient of State supplementary payments of the type referred to in section 1616(a) of this Act (or payments of the type described in section 212(a) of Public Law 93-66) if such person received such a payment for the month

before the month in which such person began to receive a benefit described in paragraph (1)(A), for so long as such person (i) would be eligible for such supplemental security income benefits, or such State supplementary payments (or payments of the type described in section 212(a) of Public Law 93-66), in the absence of benefits described in paragraph (1)(A), and (ii) is not entitled to hospital insurance benefits under part A of title XVIII.”.

(2) INCLUSION OF MONTHS OF SSI ELIGIBILITY WITHIN 5-MONTH DISABILITY WAITING PERIOD AND 24-MONTH MEDICARE WAITING PERIOD.—

(A) WIDOW’S BENEFITS BASED ON DISABILITY.—Section 202(e)(5) (42 U.S.C. 402(e)(5)) is amended—

- (i) in subparagraph (B), by striking “(i)” and “(ii)” and inserting “(I)” and “(II)”, respectively;
- (ii) by redesignating subparagraphs (A) and (B) as clauses (i) and (ii), respectively;
- (iii) by inserting “(A)” after “(5)”; and
- (iv) by adding at the end the following new subparagraph:

“(B) For purposes of paragraph (1)(F)(i), each month in the period commencing with the first month for which such widow or surviving divorced wife is first eligible for supplemental security income benefits under title XVI, or State supplementary payments of the type referred to in section 1616(a) (or payments of the type described in section 212(a) of Public Law 93-66) which are paid by the Secretary under an agreement referred to in section 1616(a) (or in section 212(b) of Public Law 93-66), shall be included as one of the months of such waiting period for which the requirements of subparagraph (A) have been met.”.

(B) WIDOWER’S BENEFITS BASED ON DISABILITY.—Section 202(f)(6) (42 U.S.C. 402(f)(6)) is amended—

- (i) in subparagraph (B), by striking “(i)” and “(ii)” and inserting “(I)” and “(II)”, respectively;
- (ii) by redesignating subparagraphs (A) and (B) as clauses (i) and (ii), respectively;
- (iii) by inserting “(A)” after “(6)”; and
- (iv) by adding at the end the following new subparagraph:

“(B) For purposes of paragraph (1)(F)(i), each month in the period commencing with the first month for which such widower or surviving divorced husband is first eligible for supplemental security income benefits under title XVI, or State supplementary payments of the type referred to in section 1616(a) (or payments of the type described in section 212(a) of Public Law 93-66) which are paid by the Secretary under an agreement referred to in section 1616(a) (or in section 212(b) of Public Law 93-66), shall be included as one of the months of such waiting period for which the requirements of subparagraph (A) have been met.”.

(C) MEDICARE BENEFITS.—Section 226(e)(1) (42 U.S.C. 426(e)(1)) is amended—

- (i) by redesignating subparagraphs (A) and (B) as clauses (i) and (ii), respectively;
- (ii) by inserting “(A)” after “(e)(1)”; and
- (iii) by adding at the end the following new subparagraph:

“(B) For purposes of subsection (b)(2)(A)(iii), each month in the period commencing with the first month for which an individual is first eligible for supplemental security income benefits under title XVI, or State supplementary payments of the type referred to in section 1616(a) of this Act (or payments of the type described in section 212(a) of Public Law 93-66) which are paid by the Secretary under an agreement referred to in section 1616(a) (or in section 212(b) of Public Law 93-66), shall be included as one of the 24 months for which such individual must have been entitled to widow’s or widower’s insurance benefits on the basis of disability in order to become entitled to hospital insurance benefits on that basis.”.

(d) **DEEMED DISABILITY FOR PURPOSES OF ENTITLEMENT TO WIDOW’S AND WIDOWER’S INSURANCE BENEFITS FOR WIDOWS AND WIDOWERS ON SSI ROLLS.**—

(1) **WIDOW’S INSURANCE BENEFITS.**—Section 202(e) (42 U.S.C. 402(e)) is amended by adding at the end the following new paragraph:

“(9) An individual shall be deemed to be under a disability for purposes of paragraph (1)(B)(ii) if such individual is eligible for supplemental security income benefits under title XVI, or State supplementary payments of the type referred to in section 1616(a) (or payments of the type described in section 212(a) of Public Law 93-66) which are paid by the Secretary under an agreement referred to in section 1616(a) (or in section 212(b) of Public Law 93-66), for the month for which all requirements of paragraph (1) for entitlement to benefits under this subsection (other than being under a disability) are met.”.

(2) **WIDOWER’S INSURANCE BENEFITS.**—Section 202(f) (42 U.S.C. 402(f)) is amended by adding at the end the following new paragraph:

“(9) An individual shall be deemed to be under a disability for purposes of paragraph (1)(B)(ii) if such individual is eligible for supplemental security income benefits under title XVI, or State supplementary payments of the type referred to in section 1616(a) (or payments of the type described in section 212(a) of Public Law 93-66) which are paid by the Secretary under an agreement referred to in such section 1616(a) (or in section 212(b) of Public Law 93-66), for the month for which all requirements of paragraph (1) for entitlement to benefits under this subsection (other than being under a disability) are met.”.

(e) **EFFECTIVE DATE.**—

42 USC 402 note.

(1) **IN GENERAL.**—The amendments made by this section (other than paragraphs (1) and (2)(C) of subsection (c)) shall apply with respect to monthly insurance benefits for months after December 1990 for which applications are filed on or after January 1, 1991, or are pending on such date. The amendments made by subsection (c)(1) shall apply with respect to medical assistance provided after December 1990. The amendments made by subsection (c)(2)(C) shall apply with respect to items and services furnished after December 1990.

(2) **APPLICATION REQUIREMENTS FOR CERTAIN INDIVIDUALS ON BENEFIT ROLLS.**—In the case of any individual who—

(A) is entitled to disability insurance benefits under section 223 of the Social Security Act for December 1990 or is eligible for supplemental security income benefits under title XVI of such Act, or State supplementary payments of

the type referred to in section 1616(a) of such Act (or payments of the type described in section 212(a) of Public Law 93-66) which are paid by the Secretary under an agreement referred to in such section 1616(a) (or in section 212(b) of Public Law 93-66), for January 1991,

(B) applied for widow's or widower's insurance benefits under subsection (e) or (f) of section 202 of the Social Security Act during 1990, and

(C) is not entitled to such benefits under such subsection (e) or (f) for any month on the basis of such application by reason of the definition of disability under section 223(d)(2)(B) of the Social Security Act (as in effect immediately before the date of the enactment of this Act), and would have been so entitled for such month on the basis of such application if the amendments made by this section had been applied with respect to such application, for purposes of determining such individual's entitlement to such benefits under subsection (e) or (f) of section 202 of the Social Security Act for months after December 1990, the requirement of paragraph (1)(C)(i) of such subsection shall be deemed to have been met.

SEC. 5104. DEPENDENCY REQUIREMENTS APPLICABLE TO A CHILD ADOPTED BY A SURVIVING SPOUSE.

(a) **IN GENERAL.**—Section 216(e) (42 U.S.C. 416(e)) is amended in the second sentence—

(1) by striking “at the time of such individual's death living in such individual's household” and inserting “either living with or receiving at least one-half of his support from such individual at the time of such individual's death”; and

(2) by striking “; except” and all that follows and inserting a period.

42 USC 416 note.

(b) **EFFECTIVE DATE.**—The amendments made by this section shall apply with respect to benefits payable for months after December 1990, but only on the basis of applications filed after December 31, 1990.

SEC. 5105. REPRESENTATIVE PAYEE REFORMS.

(a) **IMPROVEMENTS IN THE REPRESENTATIVE PAYEE SELECTION AND RECRUITMENT PROCESS.**—

(1) **AUTHORITY FOR CERTIFICATION OF PAYMENTS TO REPRESENTATIVE PAYEES.**—

(A) **TITLE II.**—Section 205(j)(1) (42 U.S.C. 405(j)) is amended to read as follows:

“REPRESENTATIVE PAYEES

“(j)(1) If the Secretary determines that the interest of any individual under this title would be served thereby, certification of payment of such individual's benefit under this title may be made, regardless of the legal competency or incompetency of the individual, either for direct payment to the individual, or for his or her use and benefit, to another individual, or an organization, with respect to whom the requirements of paragraph (2) have been met (hereinafter in this subsection referred to as the individual's ‘representative payee’). If the Secretary or a court of competent jurisdiction determines that a representative payee has misused any individual's

benefit paid to such representative payee pursuant to this subsection or section 1631(a)(2), the Secretary shall promptly revoke certification for payment of benefits to such representative payee pursuant to this subsection and certify payment to an alternative representative payee or to the individual.”.

(B) TITLE XVI.—

(i) IN GENERAL.—Section 1631(a)(2)(A) (42 U.S.C. 1383(a)(2)(A)) is amended to read as follows:

“(A)(i) Payments of the benefit of any individual may be made to any such individual or to the eligible spouse (if any) of such individual or partly to each.

“(ii) Upon a determination by the Secretary that the interest of such individual would be served thereby, or in the case of any individual or eligible spouse referred to in section 1611(e)(3)(A), such payments shall be made, regardless of the legal competency or incompetency of the individual or eligible spouse, to another individual, or an organization, with respect to whom the requirements of subparagraph (B) have been met (in this paragraph referred to as such individual’s ‘representative payee’) for the use and benefit of the individual or eligible spouse.

“(iii) If the Secretary or a court of competent jurisdiction determines that the representative payee of an individual or eligible spouse has misused any benefits which have been paid to the representative payee pursuant to clause (ii) or section 205(j)(1), the Secretary shall promptly terminate payment of benefits to the representative payee pursuant to this subparagraph, and provide for payment of benefits to the individual or eligible spouse or to an alternative representative payee of the individual or eligible spouse.”.

(ii) CONFORMING AMENDMENTS.—Section 1631(a)(2)(C) (42 U.S.C. 1383(a)(2)(C)) is amended—

(I) in clause (i), by striking “a person other than the individual or spouse entitled to such payment” and inserting “representative payee of an individual or spouse”;

(II) in clauses (ii), (iii), and (iv), by striking “other person to whom such payment is made” each place it appears and inserting “representative payee”; and

(III) in clause (v)—

(aa) by striking “person receiving payments on behalf of another” and inserting “representative payee”; and

(bb) by striking “person receiving such payments” and inserting “representative payee”.

(2) PROCEDURE FOR SELECTING REPRESENTATIVE PAYEES.—

(A) IN GENERAL.—

(i) TITLE II.—Section 205(j)(2) (42 U.S.C. 405(j)(2)) is amended to read as follows:

“(2)(A) Any certification made under paragraph (1) for payment of benefits to an individual’s representative payee shall be made on the basis of—

“(i) an investigation by the Secretary of the person to serve as representative payee, which shall be conducted in advance of such certification and shall, to the extent practicable, include a face-to-face interview with such person, and

“(ii) adequate evidence that such certification is in the interest of such individual (as determined by the Secretary in regulations).

“(B)(i) As part of the investigation referred to in subparagraph (A)(i), the Secretary shall—

“(I) require the person being investigated to submit documented proof of the identity of such person, unless information establishing such identity has been submitted with an application for benefits under this title or title XVI,

“(II) verify such person’s social security account number (or employer identification number),

“(III) determine whether such person has been convicted of a violation of section 208 or 1632, and

“(IV) determine whether certification of payment of benefits to such person has been revoked pursuant to this subsection or payment of benefits to such person has been terminated pursuant to section 1631(a)(2)(A)(iii) by reason of misuse of funds paid as benefits under this title or title XVI.

“(ii) The Secretary shall establish and maintain a centralized file, which shall be updated periodically and which shall be in a form which renders it readily retrievable by each servicing office of the Social Security Administration. Such file shall consist of—

“(I) a list of the names and social security account numbers (or employer identification numbers) of all persons with respect to whom certification of payment of benefits has been revoked on or after January 1, 1991, pursuant to this subsection, or with respect to whom payment of benefits has been terminated on or after such date pursuant to section 1631(a)(2)(A)(iii), by reason of misuse of funds paid as benefits under this title or title XVI, and

“(II) a list of the names and social security account numbers (or employer identification numbers) of all persons who have been convicted of a violation of section 208 or 1632.

“(C)(i) Benefits of an individual may not be certified for payment to any other person pursuant to this subsection if—

“(I) such person has previously been convicted as described in subparagraph (B)(i)(III),

“(II) except as provided in clause (ii), certification of payment of benefits to such person under this subsection has previously been revoked as described in subparagraph (B)(i)(IV), or payment of benefits to such person pursuant to section 1631(a)(2)(A)(ii) has previously been terminated as described in section 1631(a)(2)(B)(ii)(IV), or

“(III) except as provided in clause (iii), such person is a creditor of such individual who provides such individual with goods or services for consideration.

“(ii) The Secretary shall prescribe regulations under which the Secretary may grant exemptions to any person from the provisions of clause (i)(II) on a case-by-case basis if such exemption is in the best interest of the individual whose benefits would be paid to such person pursuant to this subsection.

“(iii) Clause (i)(III) shall not apply with respect to any person who is a creditor referred to therein if such creditor is—

“(I) a relative of such individual if such relative resides in the same household as such individual,

“(II) a legal guardian or legal representative of such individual,

“(III) a facility that is licensed or certified as a care facility under the law of a State or a political subdivision of a State,

“(IV) a person who is an administrator, owner, or employee of a facility referred to in subclause (III) if such individual resides in such facility, and the certification of payment to such facility or such person is made only after good faith efforts have been made by the local servicing office of the Social Security Administration to locate an alternative representative payee to whom such certification of payment would serve the best interests of such individual, or

“(V) an individual who is determined by the Secretary, on the basis of written findings and under procedures which the Secretary shall prescribe by regulation, to be acceptable to serve as a representative payee.

“(iv) The procedures referred to in clause (iii)(V) shall require the individual who will serve as representative payee to establish, to the satisfaction of the Secretary, that—

“(I) such individual poses no risk to the beneficiary,

“(II) the financial relationship of such individual to the beneficiary poses no substantial conflict of interest, and

“(III) no other more suitable representative payee can be found.

“(D)(i) Subject to clause (ii), if the Secretary makes a determination described in the first sentence of paragraph (1) with respect to any individual's benefit and determines that direct payment of the benefit to the individual would cause substantial harm to the individual, the Secretary may defer (in the case of initial entitlement) or suspend (in the case of existing entitlement) direct payment of such benefit to the individual, until such time as the selection of a representative payee is made pursuant to this subsection.

“(ii)(I) Except as provided in subclause (II), any deferral or suspension of direct payment of a benefit pursuant to clause (i) shall be for a period of not more than 1 month.

“(II) Subclause (I) shall not apply in any case in which the individual is, as of the date of the Secretary's determination, legally incompetent or under the age of 15.

“(iii) Payment pursuant to this subsection of any benefits which are deferred or suspended pending the selection of a representative payee shall be made to the individual or the representative payee as a single sum or over such period of time as the Secretary determines is in the best interest of the individual entitled to such benefits.

“(E)(i) Any individual who is dissatisfied with a determination by the Secretary to certify payment of such individual's benefit to a representative payee under paragraph (1) or with the designation of a particular person to serve as representative payee shall be entitled to a hearing by the Secretary to the same extent as is provided in subsection (b), and to judicial review of the Secretary's final decision as is provided in subsection (g).

“(ii) In advance of the certification of payment of an individual's benefit to a representative payee under paragraph (1), the Secretary shall provide written notice of the Secretary's initial determination to certify such payment. Such notice shall be provided to such individual, except that, if such individual—

“(I) is under the age of 15,

“(II) is an unemancipated minor under the age of 18, or

“(III) is legally incompetent,

then such notice shall be provided solely to the legal guardian or legal representative of such individual.

“(iii) Any notice described in clause (ii) shall be clearly written in language that is easily understandable to the reader, shall identify the person to be designated as such individual’s representative payee, and shall explain to the reader the right under clause (i) of such individual or of such individual’s legal guardian or legal representative—

“(I) to appeal a determination that a representative payee is necessary for such individual,

“(II) to appeal the designation of a particular person to serve as the representative payee of such individual, and

“(III) to review the evidence upon which such designation is based and submit additional evidence.”.

(ii) TITLE XVI.—Section 1631(a)(2)(B) (42 U.S.C. 1383(a)(2)(B)) is amended to read as follows:

“(B)(i) Any determination made under subparagraph (A) for payment of benefits to the representative payee of an individual or eligible spouse shall be made on the basis of—

“(I) an investigation by the Secretary of the person to serve as representative payee, which shall be conducted in advance of such payment, and shall, to the extent practicable, include a face-to-face interview with such person; and

“(II) adequate evidence that such payment is in the interest of the individual or eligible spouse (as determined by the Secretary in regulations).

“(ii) As part of the investigation referred to in clause (i)(I), the Secretary shall—

“(I) require the person being investigated to submit documented proof of the identity of such person, unless information establishing such identity was submitted with an application for benefits under title II or this title;

“(II) verify the social security account number (or employer identification number) of such person;

“(III) determine whether such person has been convicted of a violation of section 208 or 1632; and

“(IV) determine whether payment of benefits to such person has been terminated pursuant to subparagraph (A)(iii), and whether certification of payment of benefits to such person has been revoked pursuant to section 205(j), by reason of misuse of funds paid as benefits under title II or this title.

“(iii) Benefits of an individual may not be paid to any other person pursuant to subparagraph (A)(ii) if—

“(I) such person has previously been convicted as described in clause (ii)(III);

“(II) except as provided in clause (iv), payment of benefits to such person pursuant to subparagraph (A)(ii) has previously been terminated as described in clause (ii)(IV), or certification of payment of benefits to such person under section 205(j) has previously been revoked as described in section 205(j)(2)(B)(i)(IV); or

“(III) except as provided in clause (v), such person is a creditor of such individual who provides such individual with goods or services for consideration.

“(iv) The Secretary shall prescribe regulations under which the Secretary may grant an exemption from clause (iii)(II) to any person on a case-by-case basis if such exemption would be in the best

interest of the individual or eligible spouse whose benefits under this title would be paid to such person pursuant to subparagraph (A)(ii).

“(v) Clause (iii)(III) shall not apply with respect to any person who is a creditor referred to therein if such creditor is—

“(I) a relative of such individual if such relative resides in the same household as such individual;

“(II) a legal guardian or legal representative of such individual;

“(III) a facility that is licensed or certified as a care facility under the law of a State or a political subdivision of a State;

“(IV) a person who is an administrator, owner, or employee of a facility referred to in subclause (III) if such individual resides in such facility, and the payment of benefits under this title to such facility or such person is made only after good faith efforts have been made by the local servicing office of the Social Security Administration to locate an alternative representative payee to whom the payment of such benefits would serve the best interests of such individual; or

“(V) an individual who is determined by the Secretary, on the basis of written findings and under procedures which the Secretary shall prescribe by regulation, to be acceptable to serve as a representative payee.

“(vi) The procedures referred to in clause (v)(V) shall require the individual who will serve as representative payee to establish, to the satisfaction of the Secretary, that—

“(I) such individual poses no risk to the beneficiary;

“(II) the financial relationship of such individual to the beneficiary poses no substantial conflict of interest; and

“(III) no other more suitable representative payee can be found.

“(vii) Subject to clause (viii), if the Secretary makes a determination described in subparagraph (A)(ii) with respect to any individual's benefit and determines that direct payment of the benefit to the individual would cause substantial harm to the individual, the Secretary may defer (in the case of initial entitlement) or suspend (in the case of existing entitlement) direct payment of such benefit to the individual, until such time as the selection of a representative payee is made pursuant to this subparagraph.

“(viii)(I) Except as provided in subclause (II), any deferral or suspension of direct payment of a benefit pursuant to clause (vii) shall be for a period of not more than 1 month.

“(II) Subclause (I) shall not apply in any case in which the individual or eligible spouse is, as of the date of the Secretary's determination, legally incompetent, under the age 15 years, or a drug addict or alcoholic referred to in section 1611(e)(3)(A).

“(ix) Payment pursuant to this subparagraph of any benefits which are deferred or suspended pending the selection of a representative payee shall be made to the individual, or to the representative payee upon such selection, as a single sum or over such period of time as the Secretary determines is in the best interests of the individual entitled to such benefits.

“(x) Any individual who is dissatisfied with a determination by the Secretary to pay such individual's benefits to a representative payee under this title, or with the designation of a particular person to serve as representative payee, shall be entitled to a hearing by

the Secretary, and to judicial review of the Secretary's final decision, to the same extent as is provided in subsection (c).

“(xi) In advance of the first payment of an individual's benefit to a representative payee under subparagraph (A)(ii), the Secretary shall provide written notice of the Secretary's initial determination to make any such payment. Such notice shall be provided to such individual, except that, if such individual—

“(I) is under the age of 15,

“(II) is an unemancipated minor under the age of 18, or

“(III) is legally incompetent,

then such notice shall be provided solely to the legal guardian or legal representative of such individual.

“(xii) Any notice described in clause (xi) shall be clearly written in language that is easily understandable to the reader, shall identify the person to be designated as such individual's representative payee, and shall explain to the reader the right under clause (x) of such individual or of such individual's legal guardian or legal representative—

“(I) to appeal a determination that a representative payee is necessary for such individual,

“(II) to appeal the designation of a particular person to serve as the representative payee of such individual, and

“(III) to review the evidence upon which such designation is based and submit additional evidence.”

42 USC 405 note.

(B) REPORT ON FEASIBILITY OF OBTAINING READY ACCESS TO CERTAIN CRIMINAL FRAUD RECORDS.—As soon as practicable after the date of the enactment of this Act, the Secretary of Health and Human Services, in consultation with the Attorney General of the United States and the Secretary of the Treasury, shall study the feasibility of establishing and maintaining a current list, which would be readily available to local offices of the Social Security Administration for use in investigations undertaken pursuant to section 205(j)(2) or 1631(a)(2)(B) of the Social Security Act, of the names and social security account numbers of individuals who have been convicted of a violation of section 495 of title 18, United States Code. The Secretary of Health and Human Services shall, not later than July 1, 1992, submit the results of such study, together with any recommendations, to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate.

(3) PROVISION FOR COMPENSATION OF QUALIFIED ORGANIZATIONS SERVING AS REPRESENTATIVE PAYEES.—

(A) IN GENERAL.—

(i) TITLE II.—Section 205(j) (42 U.S.C. 405(j)) is amended by redesignating paragraph (4) as paragraph (5), and by inserting after paragraph (3) the following new paragraph:

“(4)(A) A qualified organization may collect from an individual a monthly fee for expenses (including overhead) incurred by such organization in providing services performed as such individual's representative payee pursuant to this subsection if such fee does not exceed the lesser of—

“(i) 10 percent of the monthly benefit involved, or

“(ii) \$25.00 per month.

Any agreement providing for a fee in excess of the amount permitted under this subparagraph shall be void and shall be treated as misuse by such organization of such individual's benefits.

“(B) For purposes of this paragraph, the term ‘qualified organization’ means any community-based nonprofit social service agency which is bonded or licensed in each State in which it serves as a representative payee and which, in accordance with any applicable regulations of the Secretary—

“(i) regularly provides services as the representative payee, pursuant to this subsection or section 1631(a)(2), concurrently to 5 or more individuals,

“(ii) demonstrates to the satisfaction of the Secretary that such agency is not otherwise a creditor of any such individual, and

“(iii) was in existence on October 1, 1988.

The Secretary shall prescribe regulations under which the Secretary may grant an exception from clause (ii) for any individual on a case-by-case basis if such exception is in the best interests of such individual.

“(C) Any qualified organization which knowingly charges or collects, directly or indirectly, any fee in excess of the maximum fee prescribed under subparagraph (A) or makes any agreement, directly or indirectly, to charge or collect any fee in excess of such maximum fee, shall be fined in accordance with title 18, United States Code, or imprisoned not more than 6 months, or both.

“(D) This paragraph shall cease to be effective on July 1, 1994.”.

(ii) TITLE XVI.—Section 1631(a)(2) (42 U.S.C. 1383(a)(2)) is amended—

(I) by redesignating subparagraph (D) as subparagraph (E);

(III)⁶² by inserting after subparagraph (C) the following:

“(D)(i) A qualified organization may collect from an individual a monthly fee for expenses (including overhead) incurred by such organization in providing services performed as such individual's representative payee pursuant to subparagraph (A)(ii) if the fee does not exceed the lesser of—

“(I) 10 percent of the monthly benefit involved, or

“(II) \$25.00 per month.

Any agreement providing for a fee in excess of the amount permitted under this clause shall be void and shall be treated as misuse by the organization of such individual's benefits.

“(ii) For purposes of this subparagraph, the term ‘qualified organization’ means any community-based nonprofit social service agency which—

“(I) is bonded or licensed in each State in which the agency serves as a representative payee;

“(II) in accordance with any applicable regulations of the Secretary—

“(aa) regularly provides services as a representative payee pursuant to subparagraph (A)(ii) or section 205(j)(4) concurrently to 5 or more individuals;

“(bb) demonstrates to the satisfaction of the Secretary that such agency is not otherwise a creditor of any such individual; and

“(cc) was in existence on October 1, 1988.

⁶² So in original. Probably should be “(II)”.

The Secretary shall prescribe regulations under which the Secretary may grant an exception from subclause (II)(bb) for any individual on a case-by-case basis if such exception is in the best interests of such individual.

“(iii) Any qualified organization which knowingly charges or collects, directly or indirectly, any fee in excess of the maximum fee prescribed under clause (i) or makes any agreement, directly or indirectly, to charge or collect any fee in excess of such maximum fee, shall be fined in accordance with title 18, United States Code, or imprisoned not more than 6 months, or both.

“(iv) This subparagraph shall cease to be effective on July 1, 1994.”.

42 USC 405 note.

(B) STUDIES AND REPORTS.—

(i) **REPORT BY SECRETARY OF HEALTH AND HUMAN SERVICES.**—Not later than January 1, 1993, the Secretary of Health and Human Services shall transmit a report to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate setting forth the number and types of qualified organizations which have served as representative payees and have collected fees for such service pursuant to any amendment made by subparagraph (A).

(ii) **REPORT BY COMPTROLLER GENERAL.**—Not later than July 1, 1992, the Comptroller General of the United States shall conduct a study of the advantages and disadvantages of allowing qualified organizations serving as representative payees to charge fees pursuant to the amendments made by subparagraph (A) and shall transmit a report to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate setting forth the results of such study.

42 USC 405 note.

(4) **STUDY RELATING TO FEASIBILITY OF SCREENING OF INDIVIDUALS WITH CRIMINAL RECORDS.**—As soon as practicable after the date of the enactment of this Act, the Secretary of Health and Human Services shall conduct a study of the feasibility of determining the type of representative payee applicant most likely to have a felony or misdemeanor conviction, the suitability of individuals with prior convictions to serve as representative payees, and the circumstances under which such applicants could be allowed to serve as representative payees. The Secretary shall transmit the results of such study to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate not later than July 1, 1992.

42 USC 405 note.

(5) EFFECTIVE DATES.—

(A) **USE AND SELECTION OF REPRESENTATIVE PAYEES.**—The amendments made by paragraphs (1) and (2) shall take effect July 1, 1991, and shall apply only with respect to—

(i) certifications of payment of benefits under title II of the Social Security Act to representative payees made on or after such date; and

(ii) provisions for payment of benefits under title XVI of such Act to representative payees made on or after such date.

(B) **COMPENSATION OF REPRESENTATIVE PAYEES.**—The amendments made by paragraph (3) shall take effect July 1,

1991, and the Secretary of Health and Human Services shall prescribe initial regulations necessary to carry out such amendments not later than such date.

(b) IMPROVEMENTS IN RECORDKEEPING AND AUDITING REQUIREMENTS.—

(1) IMPROVED ACCESS TO CERTAIN INFORMATION.—

(A) IN GENERAL.—Section 205(j)(3) (42 U.S.C. 605(j)(3)) is 42 USC 405. amended—

- (i) by striking subparagraph (B);
- (ii) by redesignating subparagraphs (C), (D), and (E) as subparagraphs (B), (C), and (D), respectively;
- (iii) in subparagraph (D) (as so redesignated), by striking “(A), (B), (C), and (D)” and inserting “(A), (B), and (C)”; and
- (iv) by adding at the end the following new subparagraphs:

“(E) The Secretary shall maintain a centralized file, which shall be updated periodically and which shall be in a form which will be readily retrievable by each servicing office of the Social Security Administration, of—

“(i) the address and the social security account number (or employer identification number) of each representative payee who is receiving benefit payments pursuant to this subsection or section 1631(a)(2), and

“(ii) the address and social security account number of each individual for whom each representative payee is reported to be providing services as representative payee pursuant to this subsection or section 1631(a)(2).

“(F) Each servicing office of the Administration shall maintain a list, which shall be updated periodically, of public agencies and community-based nonprofit social service agencies which are qualified to serve as representative payees pursuant to this subsection or section 1631(a)(2) and which are located in the area served by such servicing office.”.

(B) EFFECTIVE DATE.—The amendments made by subparagraph (A) shall take effect October 1, 1992, and the Secretary of Health and Human Services shall take such actions as are necessary to ensure that the requirements of section 205(j)(3)(E) of the Social Security Act (as amended by subparagraph (A) of this paragraph) are satisfied as of such date. 42 USC 405 note.

(2) STUDY RELATING TO MORE STRINGENT OVERSIGHT OF HIGH-RISK REPRESENTATIVE PAYEES.— 42 USC 405 note.

(A) IN GENERAL.—As soon as practicable after the date of the enactment of this Act, the Secretary of Health and Human Services shall conduct a study of the need for a more stringent accounting system for high-risk representative payees than is otherwise generally provided under section 205(j)(3) or 1631(a)(2)(C) of the Social Security Act, which would include such additional reporting requirements, record maintenance requirements, and other measures as the Secretary considers necessary to determine whether services are being appropriately provided by such payees in accordance with such sections 205(j) and 1631(a)(2).

(B) **SPECIAL PROCEDURES.**—In such study, the Secretary shall determine the appropriate means of implementing more stringent, statistically valid procedures for—

(i) reviewing reports which would be submitted to the Secretary under any system described in subparagraph (A), and

(ii) periodic, random audits of records which would be kept under such a system,

in order to identify any instances in which high-risk representative payees are misusing payments made pursuant to section 205(j) or 1631(a)(2) of the Social Security Act.

(C) **HIGH-RISK REPRESENTATIVE PAYEE.**—For purposes of this paragraph, the term “high-risk representative payee” means a representative payee under section 205(j) or 1631(a)(2) of the Social Security Act (42 U.S.C. 405(j) and 1383(a)(2), respectively) (other than a Federal or State institution) who—

(i) regularly provides concurrent services as a representative payee under such section 205(j), such section 1631(a)(2), or both such sections, for 5 or more individuals who are unrelated to such representative payee,

(ii) is neither related to an individual on whose behalf the payee is being paid benefits nor living in the same household with such individual,

(iii) is a creditor of such individual, or

(iv) is in such other category of payees as the Secretary may determine appropriate.

(D) **REPORT.**—The Secretary shall report to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate the results of the study, together with any recommendations, not later than July 1, 1992. Such report shall include an evaluation of the feasibility and desirability of legislation implementing stricter accounting and review procedures for high-risk representative payees in all servicing offices of the Social Security Administration (together with proposed legislative language).

(3) **DEMONSTRATION PROJECTS RELATING TO PROVISION OF INFORMATION TO LOCAL AGENCIES PROVIDING CHILD AND ADULT PROTECTIVE SERVICES.**—

(A) **IN GENERAL.**—As soon as practicable after the date of the enactment of this Act, the Secretary of Health and Human Services shall implement a demonstration project under this paragraph in all or part of not fewer than 2 States. Under each such project, the Secretary shall enter into an agreement with the State in which the project is located to make readily available, for the duration of the project, to the appropriate State agency, a listing of addresses of multiple benefit recipients.

(B) **LISTING OF ADDRESSES OF MULTIPLE BENEFIT RECIPIENTS.**—The list referred to in subparagraph (A) shall consist of a current list setting forth each address within the State at which benefits under title II, benefits under title XVI, or any combination of such benefits are being received by 5 or more individuals. For purposes of this subparagraph, in the case of benefits under title II, all individuals receiving

benefits on the basis of the wages and self-employment income of the same individual shall be counted as 1 individual.

(C) APPROPRIATE STATE AGENCY.—The appropriate State agency referred to in subparagraph (A) is the agency of the State which the Secretary determines is primarily responsible for regulating care facilities operated in such State or providing for child and adult protective services in such State.

(D) REPORT.—The Secretary shall report to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate concerning such demonstration projects, together with any recommendations, not later than July 1, 1992. Such report shall include an evaluation of the feasibility and desirability of legislation implementing the programs established pursuant to this paragraph on a permanent basis.

(E) STATE.—For purposes of this paragraph, the term “State” means a State, including the entities included in such term by section 210(h) of the Social Security Act (42 U.S.C. 410(h)).

(c) RESTITUTION.—

(1) TITLE II.—Section 205(j) (42 U.S.C. 405(j)) is amended by redesignating paragraph (5) (as so redesignated by subsection (a)(3)(A)(i) of this section) as paragraph (6) and by inserting after paragraph (4) (as added by subsection (a)(3)(A)(i)) the following new paragraph:

“(5) In cases where the negligent failure of the Secretary to investigate or monitor a representative payee results in misuse of benefits by the representative payee, the Secretary shall certify for payment to the beneficiary or the beneficiary’s alternative representative payee an amount equal to such misused benefits. The Secretary shall make a good faith effort to obtain restitution from the terminated representative payee.”.

(2) TITLE XVI.—Section 1631(a)(2) (42 U.S.C. 1383(a)(2)) is amended by redesignating subparagraph (E) (as so redesignated by subsection (a)(3)(A)(ii)(I) of this section) as subparagraph (F) and by inserting after subparagraph (D) (as added by subsection (a)(3)(A)(i)(III)) the following new subparagraph:

“(E) RESTITUTION.—In cases where the negligent failure of the Secretary to investigate or monitor a representative payee results in misuse of benefits by the representative payee, the Secretary shall make payment to the beneficiary or the beneficiary’s representative payee of an amount equal to such misused benefits. The Secretary shall make a good faith effort to obtain restitution from the terminated representative payee.”.

(d) REPORTS TO THE CONGRESS.—

(1) IN GENERAL.—

(A) TITLE II.—Section 205(j)(5) (as so redesignated by subsection (c)(1) of this section) is amended to read as follows:

“(5) The Secretary shall include as a part of the annual report required under section 704 information with respect to the implementation of the preceding provisions of this subsection, including the number of cases in which the representative payee was changed, the number of cases discovered where there has been a

misuse of funds, how any such cases were dealt with by the Secretary, the final disposition of such cases, including any criminal penalties imposed, and such other information as the Secretary determines to be appropriate.”.

(B) TITLE XVI.—Section 1631(a)(2)(E) (42 U.S.C. 1383(a)(2)(E)), as so redesignated by subsection (c)(2) of this section, is amended to read as follows:

“(E) The Secretary shall include as a part of the annual report required under section 704 information with respect to the implementation of the preceding provisions of this paragraph, including—

“(i) the number of cases in which the representative payee was changed;

“(ii) the number of cases discovered where there has been a misuse of funds;

“(iii) how any such cases were dealt with by the Secretary;

“(iv) the final disposition of such cases (including any criminal penalties imposed); and

“(v) such other information as the Secretary determines to be appropriate.”.

42 USC 405 note.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply with respect to annual reports issued for years after 1991.

(3) FEASIBILITY STUDY REGARDING INVOLVEMENT OF DEPARTMENT OF VETERANS AFFAIRS.—As soon as practicable after the date of the enactment of this Act, the Secretary of Health and Human Services, in cooperation with the Secretary of Veterans Affairs, shall conduct a study of the feasibility of designating the Department of Veterans Affairs as the lead agency for purposes of selecting, appointing, and monitoring representative payees for those individuals who receive benefits paid under title II or XVI of the Social Security Act and benefits paid by the Department of Veterans Affairs. Not later than 180 days after the date of the enactment of this Act, the Secretary of Health and Human Services shall transmit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate a report setting forth the results of such study, together with any recommendations.

SEC. 5106. FEES FOR REPRESENTATION OF CLAIMANTS IN ADMINISTRATIVE PROCEEDINGS.

(a) IN GENERAL.—

(1) TITLE II.—Subsection (a) of section 206 (42 U.S.C. 406(a)) is amended—

(A) by inserting “(1)” after “(a)”;

(B) in the fifth sentence, by striking “Whenever” and inserting “Except as provided in paragraph (2)(A), whenever”; and

(C) by striking the sixth sentence and all that follows through “Any person who” in the seventh sentence and inserting the following:

“(2)(A) In the case of a claim of entitlement to past-due benefits under this title, if—

“(i) an agreement between the claimant and another person regarding any fee to be recovered by such person to compensate such person for services with respect to the claim is presented in

writing to the Secretary prior to the time of the Secretary's determination regarding the claim,

“(ii) the fee specified in the agreement does not exceed the lesser of—

“(I) 25 percent of the total amount of such past-due benefits (as determined before any applicable reduction under section 1127(a)), or

“(II) \$4,000, and

“(iii) the determination is favorable to the claimant,

then the Secretary shall approve that agreement at the time of the favorable determination, and (subject to paragraph (3)) the fee specified in the agreement shall be the maximum fee. The Secretary may from time to time increase the dollar amount under clause (ii)(II) to the extent that the rate of increase in such amount, as determined over the period since January 1, 1991, does not at any time exceed the rate of increase in primary insurance amounts under section 215(i) since such date. The Secretary shall publish any such increased amount in the Federal Register.

“(B) For purposes of this subsection, the term ‘past-due benefits’ excludes any benefits with respect to which payment has been continued pursuant to subsection (g) or (h) of section 223.

“(C) In the case of a claim with respect to which the Secretary has approved an agreement pursuant to subparagraph (A), the Secretary shall provide the claimant and the person representing the claimant a written notice of—

“(i) the dollar amount of the past-due benefits (as determined before any applicable reduction under section 1127(a)) and the dollar amount of the past-due benefits payable to the claimant,

“(ii) the dollar amount of the maximum fee which may be charged or recovered as determined under this paragraph, and

“(iii) a description of the procedures for review under paragraph (3).

“(3)(A) The Secretary shall provide by regulation for review of the amount which would otherwise be the maximum fee as determined under paragraph (2) if, within 15 days after receipt of the notice provided pursuant to paragraph (2)(C)—

“(i) the claimant, or the administrative law judge or other adjudicator who made the favorable determination, submits a written request to the Secretary to reduce the maximum fee, or

“(ii) the person representing the claimant submits a written request to the Secretary to increase the maximum fee.

Any such review shall be conducted after providing the claimant, the person representing the claimant, and the adjudicator with reasonable notice of such request and an opportunity to submit written information in favor of or in opposition to such request. The adjudicator may request the Secretary to reduce the maximum fee only on the basis of evidence of the failure of the person representing the claimant to represent adequately the claimant's interest or on the basis of evidence that the fee is clearly excessive for services rendered.

“(B)(i) In the case of a request for review under subparagraph (A) by the claimant or by the person representing the claimant, such review shall be conducted by the administrative law judge who made the favorable determination or, if the Secretary determines that such administrative law judge is unavailable or if the determination was not made by an administrative law judge, such review

shall be conducted by another person designated by the Secretary for such purpose.

“(ii) In the case of a request by the adjudicator for review under subparagraph (A), the review shall be conducted by the Secretary or by an administrative law judge or other person (other than such adjudicator) who is designated by the Secretary.

“(C) Upon completion of the review, the administrative law judge or other person conducting the review shall affirm or modify the amount which would otherwise be the maximum fee. Any such amount so affirmed or modified shall be considered the amount of the maximum fee which may be recovered under paragraph (2). The decision of the administrative law judge or other person conducting the review shall not be subject to further review.

“(4)(A) Subject to subparagraph (B), if the claimant is determined to be entitled to past-due benefits under this title and the person representing the claimant is an attorney, the Secretary shall, notwithstanding section 205(i), certify for payment out of such past-due benefits (as determined before any applicable reduction under section 1127(a)) to such attorney an amount equal to so much of the maximum fee as does not exceed 25 percent of such past-due benefits (as determined before any applicable reduction under section 1127(a)).

“(B) The Secretary shall not in any case certify any amount for payment to the attorney pursuant to this paragraph before the expiration of the 15-day period referred to in paragraph (3)(A) or, in the case of any review conducted under paragraph (3), before the completion of such review.

“(5) Any person who”.

(2) TITLE XVI.—Paragraph (2)(A) of section 1631(d) (42 U.S.C. 1383(d)(2)(A)) is amended to read as follows:

“(2)(A) The provisions of section 206(a) (other than paragraph (4) thereof) shall apply to this part to the same extent as they apply in the case of title II, except that paragraph (2) thereof shall be applied—

“(i) by substituting ‘section 1127(a) or 1631(g)’ for ‘section 1127(a)’; and

“(ii) by substituting ‘section 1631(a)(7)(A) or the requirements of due process of law’ for ‘subsection (g) or (h) of section 223’.”.

(b) PROTECTION OF ATTORNEY’S FEES FROM OFFSETTING SSI BENEFITS.—Subsection (a) of section 1127 (42 U.S.C. 1320a-6(a)) is amended by adding at the end the following new sentence: “A benefit under title II shall not be reduced pursuant to the preceding sentence to the extent that any amount of such benefit would not otherwise be available for payment in full of the maximum fee which may be recovered from such benefit by an attorney pursuant to section 206(a)(4).”.

(c) LIMITATION OF TRAVEL EXPENSES FOR REPRESENTATION OF CLAIMANTS AT ADMINISTRATIVE PROCEEDINGS.—Section 201(j) (42 U.S.C. 401(j)), section 1631(h) (42 U.S.C. 1383(h)), and section 1817(i) (42 U.S.C. 1395i(i)) are each amended by adding at the end the following new sentence: “The amount available for payment under this subsection for travel by a representative to attend an administrative proceeding before an administrative law judge or other adjudicator shall not exceed the maximum amount allowable under this subsection for such travel originating within the geographic area of the office having jurisdiction over such proceeding.”.

(d) **EFFECTIVE DATE.**—The amendments made by this section shall apply with respect to determinations made on or after July 1, 1991, and to reimbursement for travel expenses incurred on or after April 1, 1991. 42 USC 401 note.

SEC. 5107. APPLICABILITY OF ADMINISTRATIVE RES JUDICATA; RELATED NOTICE REQUIREMENTS.

(a) **IN GENERAL.**—

(1) **TITLE II.**—Section 205(b) (42 U.S.C. 405(b)) is amended by adding at the end the following new paragraph:

“(3)(A) A failure to timely request review of an initial adverse determination with respect to an application for any benefit under this title or an adverse determination on reconsideration of such an initial determination shall not serve as a basis for denial of a subsequent application for any benefit under this title if the applicant demonstrates that the applicant, or any other individual referred to in paragraph (1), failed to so request such a review acting in good faith reliance upon incorrect, incomplete, or misleading information, relating to the consequences of reapplying for benefits in lieu of seeking review of an adverse determination, provided by any officer or employee of the Social Security Administration or any State agency acting under section 221.

“(B) In any notice of an adverse determination with respect to which a review may be requested under paragraph (1), the Secretary shall describe in clear and specific language the effect on possible entitlement to benefits under this title of choosing to reapply in lieu of requesting review of the determination.”.

(2) **TITLE XVI.**—Section 1631(c)(1) (42 U.S.C. 1383(c)(1)) is amended—

(A) by inserting “(A)” after “(c)(1)”; and

(B) by adding at the end the following:

“(B)(i) A failure to timely request review of an initial adverse determination with respect to an application for any payment under this title or an adverse determination on reconsideration of such an initial determination shall not serve as a basis for denial of a subsequent application for any payment under this title if the applicant demonstrates that the applicant, or any other individual referred to in paragraph (1), failed to so request such a review acting in good faith reliance upon incorrect, incomplete, or misleading information, relating to the consequences of reapplying for payments in lieu of seeking review of an adverse determination, provided by any officer or employee of the Social Security Administration or any State agency acting under section 221.

“(ii) In any notice of an adverse determination with respect to which a review may be requested under paragraph (1), the Secretary shall describe in clear and specific language the effect on possible eligibility to receive payments under this title of choosing to reapply in lieu of requesting review of the determination.”.

(b) **EFFECTIVE DATE.**—The amendments made by this section shall apply with respect to adverse determinations made on or after July 1, 1991. 42 USC 405 note.

SEC. 5108. DEMONSTRATION PROJECTS RELATING TO ACCOUNTABILITY FOR TELEPHONE SERVICE CENTER COMMUNICATIONS. 42 USC 902 note.

(a) **IN GENERAL.**—The Secretary of Health and Human Services shall develop and carry out demonstration projects designed to

implement the accountability procedures described in subsection (b) in each of not fewer than 3 telephone service centers operated by the Social Security Administration. Telephone service centers shall be selected for implementation of the accountability procedures so as to permit a thorough evaluation of such procedures as they would operate in conjunction with the service technology most recently employed by the Social Security Administration. Each such demonstration project shall commence not later than 180 days after the date of the enactment of this Act and shall remain in operation for not less than 1 year and not more than 3 years.

(b) ACCOUNTABILITY PROCEDURES.—

(1) **IN GENERAL.**—During the period of each demonstration project developed and carried out by the Secretary of Health and Human Services with respect to a telephone service center pursuant to subsection (a), the Secretary shall provide for the application at such telephone service center of accountability procedures consisting of the following:

(A) In any case in which a person communicates with the Social Security Administration by telephone at such telephone service center and provides in such communication his or her name, address, and such other identifying information as the Secretary determines necessary and appropriate for purposes of this subparagraph, the Secretary must thereafter promptly provide such person a written receipt which sets forth—

(i) the name of any individual representing the Social Security Administration with whom such person has spoken in such communication,

(ii) the date of the communication;

(iii) a description of the nature of the communication,

(iv) any action that an individual representing the Social Security Administration has indicated in the communication will be taken in response to the communication, and

(v) a description of the information or advice offered in the communication by an individual representing the Social Security Administration.

(B) Such person must be notified during the communication by an individual representing the Social Security Administration that, if adequate identifying information is provided to the Administration, a receipt described in subparagraph (A) will be provided to such person.

(C) A copy of any receipt required to be provided to any person under subparagraph (A) must be—

(i) included in the file maintained by the Social Security Administration relating to such person, or

(ii) if there is no such file, otherwise retained by the Social Security Administration in retrievable form until the end of the 5-year period following the termination of the project.

(2) **EXCLUSION OF CERTAIN ROUTINE TELEPHONE COMMUNICATIONS.**—The Secretary may exclude from demonstration projects carried out pursuant to this section routine telephone communications which do not relate to potential or current eligibility or entitlement to benefits.

(c) REPORT.—

(1) IN GENERAL ⁶³—The Secretary of Health and Human Services shall submit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate a written report on the progress of the demonstration projects conducted pursuant to this section, together with any related data and materials which the Secretary may consider appropriate. The report shall be submitted not later than 90 days after the termination of the project.

(2) SPECIFIC MATTERS TO BE INCLUDED.—The report required under paragraph (1) shall—

(A) assess the costs and benefits of the accountability procedures,

(B) identify any major difficulties encountered in implementing the demonstration project, and

(C) assess the feasibility of implementing the accountability procedures on a national basis.

SEC. 5109. NOTICE REQUIREMENTS.

(a) REQUIREMENTS.—

(1) TITLE II.—Section 205 (42 U.S.C. 405) is amended by inserting after subsection (r) the following new subsection:

“NOTICE REQUIREMENTS

“(s) The Secretary shall take such actions as are necessary to ensure that any notice to one or more individuals issued pursuant to this title by the Secretary or by a State agency—

“(1) is written in simple and clear language, and

“(2) includes the address and telephone number of the local office of the Social Security Administration which serves the recipient.

In the case of any such notice which is not generated by a local servicing office, the requirements of paragraph (2) shall be treated as satisfied if such notice includes the address of the local office of the Social Security Administration which services the recipient of the notice and a telephone number through which such office can be reached.”.

(2) TITLE XVI.—Section 1631 (42 U.S.C. 1383) is amended by adding at the end the following:

“NOTICE REQUIREMENTS

“(n) The Secretary shall take such actions as are necessary to ensure that any notice to one or more individuals issued pursuant to this title by the Secretary or by a State agency—

“(1) is written in simple and clear language, and

“(2) includes the address and telephone number of the local office of the Social Security Administration which serves the recipient.

In the case of any such notice which is not generated by a local servicing office, the requirements of paragraph (2) shall be treated as satisfied if such notice includes the address of the local office of the Social Security Administration which services the recipient of the notice and a telephone number through which such office can be reached.”.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to notices issued on or after July 1, 1991.

42 USC 405 note.

⁶³ So in original. Probably should be “GENERAL.—”.

42 USC 902 note.

SEC. 5110. TELEPHONE ACCESS TO THE SOCIAL SECURITY ADMINISTRATION.

(a) **REQUIRED MINIMUM LEVEL OF ACCESS TO LOCAL OFFICES.**—In addition to such other access by telephone to offices of the Social Security Administration as the Secretary of Health and Human Services may consider appropriate, the Secretary shall maintain access by telephone to local offices of the Social Security Administration at the level of access generally available as of September 30, 1989.

(b) **TELEPHONE LISTINGS.**—The Secretary shall make such requests of local telephone utilities in the United States as are necessary to ensure that the listings subsequently maintained and published by such utilities for each locality include the address and telephone number for each local office of the Social Security Administration to which direct telephone access is maintained under subsection (a) in such locality. Such listing may also include information concerning the availability of a toll-free number which may be called for general information.

(c) **REPORT BY SECRETARY.**—Not later than January 1, 1993, the Secretary shall submit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate a report which—

(1) assesses the impact of the requirements established by this section on the Social Security Administration's allocation of resources, workload levels, and service to the public, and

(2) presents a plan for using new, innovative technologies to enhance access to the Social Security Administration, including access to local offices.

(d) **GAO REPORT.**—The Comptroller General of the United States shall review the level of telephone access by the public to the local offices of the Social Security Administration. The Comptroller General shall file an interim report with the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate describing such level of telephone access not later than 120 days after the date of the enactment of this Act and shall file a final report with such Committees describing such level of access not later than 210 days after such date.

(e) **EFFECTIVE DATE.**—The Secretary of Health and Human Services shall meet the requirements of subsections (a) and (b) as soon as possible after the date of the enactment of this Act but not later 180 days after such date.

SEC. 5111. AMENDMENTS RELATING TO SOCIAL SECURITY ACCOUNT STATEMENTS.

(a) **IN GENERAL.**—Section 1142 (42 U.S.C. 1320b-13), as added by section 10308 of the Omnibus Budget Reconciliation Act of 1989 (103 Stat. 2485), is amended—

(1) by striking “SEC. 1142.” and inserting “SEC. 1143.”; and

(2) in subsection (c)(2), by striking “a biennial” and inserting “an annual”.

(b) **DISCLOSURE OF ADDRESS INFORMATION BY INTERNAL REVENUE SERVICE TO SOCIAL SECURITY ADMINISTRATION.**—

(1) **IN GENERAL.**—Section 6103(m) of the Internal Revenue Code of 1986 (relating to disclosure of taxpayer identity information) is amended by adding at the end the following new paragraph:

26 USC 6103.

“(7) SOCIAL SECURITY ACCOUNT STATEMENT FURNISHED BY SOCIAL SECURITY ADMINISTRATION.—Upon written request by the Commissioner of Social Security, the Secretary may disclose the mailing address of any taxpayer who is entitled to receive a social security account statement pursuant to section 1143(c) of the Social Security Act, for use only by officers, employees or agents of the Social Security Administration for purposes of mailing such statement to such taxpayer.”.

(2) SAFEGUARDS.—Section 6103(p)(4) of such Code (relating to safeguards) is amended, in the matter following subparagraph (f)(iii), by striking “subsection (m)(2), (4), or (6)” and inserting “paragraph (2), (4), (6), or (7) of subsection (m)”.

(3) UNAUTHORIZED DISCLOSURE PENALTIES.—Paragraph (2) of section 7213(a) of such Code (relating to unauthorized disclosure of returns and return information) is amended by striking “(m)(2), (4), or (6)” and inserting “(m)(2), (4), (6), or (7)”.

SEC. 5112. TRIAL WORK PERIOD DURING ROLLING FIVE-YEAR PERIOD FOR ALL DISABLED BENEFICIARIES.

(a) IN GENERAL.—Section 222(c) (42 U.S.C. 422(c)) is amended—

(1) in paragraph (4)(A), by striking “, beginning on or after the first day of such period,” and inserting “, in any period of 60 consecutive months,”; and

(2) by striking paragraph (5).

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall take effect on January 1, 1992. 42 USC 422 note.

SEC. 5113. CONTINUATION OF BENEFITS ON ACCOUNT OF PARTICIPATION IN A NON-STATE VOCATIONAL REHABILITATION PROGRAM.

(a) IN GENERAL.—Section 225(b) (42 U.S.C. 425(b)) is amended—

(1) by striking paragraph (1) and inserting the following new paragraph:

“(1) such individual is participating in a program of vocational rehabilitation services approved by the Secretary, and”; and

(2) in paragraph (2), by striking “Commissioner of Social Security” and inserting “Secretary”.

(b) PAYMENTS AND PROCEDURES.—Section 1631(a)(6) (42 U.S.C. 1383(a)(6)) is amended—

(1) by striking subparagraph (A) and inserting the following new subparagraph:

“(A) such individual is participating in a program of vocational rehabilitation services approved by the Secretary, and”; and

(2) in subparagraph (B), by striking “Commissioner of Social Security” and inserting “Secretary”.

(c) EFFECTIVE DATE.—The amendments made by this section shall be effective with respect to benefits payable for months after the eleventh month following the month in which this Act is enacted and shall apply only with respect to individuals whose blindness or disability has or may have ceased after such eleventh month. 42 USC 425 note.

SEC. 5114. LIMITATION ON NEW ENTITLEMENT TO SPECIAL AGE-72 PAYMENTS.

(a) IN GENERAL.—Section 228(a)(2) (42 U.S.C. 428(a)(2)) is amended by striking “(B)” and inserting “(B)(i) attained such age after 1967 and before 1972, and (ii)”.

42 USC 428 note.

(b) **EFFECTIVE DATE**—The amendment made by subsection (a) shall apply with respect to benefits payable on the basis of applications filed after the date of the enactment of this Act.

SEC. 5115. ELIMINATION OF ADVANCED CREDITING TO THE TRUST FUNDS OF SOCIAL SECURITY PAYROLL TAXES.

(a) **IN GENERAL**.—Section 201(a) (42 U.S.C. 401(a)) is amended—

(1) in the first sentence following clause (4)—

(A) by striking “monthly on the first day of each calendar month” both places it appears and inserting “from time to time”;

(B) by striking “to be paid to or deposited into the Treasury during such month” and inserting “paid to or deposited into the Treasury”; and

(2) in the last sentence, by striking “Fund;” and inserting “Fund. Notwithstanding the preceding sentence, in any case in which the Secretary of the Treasury determines that the assets of either such Trust Fund would otherwise be inadequate to meet such Fund’s obligations for any month, the Secretary of the Treasury shall transfer to such Trust Fund on the first day of such month the amount which would have been transferred to such Fund under this section as in effect on October 1, 1990; and”.

42 USC 401 note.

(c) **EFFECTIVE DATE**.—The amendments made by this section shall become effective on the first day of the month following the month in which this Act is enacted.

SEC. 5116. ELIMINATION OF ELIGIBILITY FOR RETROACTIVE BENEFITS FOR CERTAIN INDIVIDUALS ELIGIBLE FOR REDUCED BENEFITS.

(a) **IN GENERAL**.—Section 202(j)(4) (42 U.S.C. 402(j)(4)) is amended—

(1) in subparagraph (A), by striking “if the effect” and all that follows and inserting “if the amount of the monthly benefit to which such individual would otherwise be entitled for any such month would be subject to reduction pursuant to subsection (q).”; and

(2) in subparagraph (B), by striking clauses (i) and (iv) and by redesignating clauses (ii), (iii), and (v) as clauses (i), (ii), and (iii), respectively.

42 USC 402 note.

(b) **EFFECTIVE DATE**.—The amendments made by this section shall apply with respect to applications for benefits filed on or after January 1, 1991.

SEC. 5117. CONSOLIDATION OF OLD METHODS OF COMPUTING PRIMARY INSURANCE AMOUNTS.

(a) **CONSOLIDATION OF COMPUTATION METHODS**.—

(1) **IN GENERAL**.—Section 215(a)(5) (42 U.S.C. 415(a)(5)) is amended—

(A) by striking “For purposes of” and inserting “(A) Subject to subparagraphs (B), (C), (D) and (E), for purposes of”;

(B) by striking the last sentence; and

(C) by adding at the end the following new subparagraphs:

“(B)(i) Subject to clauses (ii), (iii), and (iv), and notwithstanding any other provision of law, the primary insurance amount of any individual described in subparagraph (C) shall be, in lieu of the

primary insurance amount as computed pursuant to any of the provisions referred to in subparagraph (D), the primary insurance amount computed under subsection (a) of section 215 as in effect in December 1978, without regard to subsection (b)(4) and (c) of such section as so in effect.

“(ii) The computation of a primary insurance amount under this subparagraph shall be subject to section 104(j)(2) of the Social Security Amendments of 1972 (relating to the number of elapsed years under section 215(b)).

“(iii) In computing a primary insurance amount under this subparagraph, the dollar amount specified in paragraph (3) of section 215(a) (as in effect in December 1978) shall be increased to \$11.50.

“(iv) In the case of an individual to whom section 215(d) applies, the primary insurance amount of such individual shall be the greater of—

“(I) the primary insurance amount computed under the preceding clauses of this subparagraph, or

“(II) the primary insurance amount computed under section 215(d).

“(C) An individual is described in this subparagraph if—

“(i) paragraph (1) does not apply to such individual by reason of such individual's eligibility for an old-age or disability insurance benefit, or the individual's death, prior to 1979, and

“(ii) such individual's primary insurance amount computed under this section as in effect immediately before the date of the enactment of the Omnibus Budget Reconciliation Act of 1990 would have been computed under the provisions described in subparagraph (D).

“(D) The provisions described in this subparagraph are—

“(i) the provisions of this subsection as in effect prior to the enactment of the Social Security Amendments of 1965, if such provisions would preclude the use of wages prior to 1951 in the computation of the primary insurance amount,

“(ii) the provisions of section 209 as in effect prior to the enactment of the Social Security Act Amendments of 1950, and

“(iii) the provisions of section 215(d) as in effect prior to the enactment of the Social Security Amendments of 1977.

“(E) For purposes of this paragraph, the table for determining primary insurance amounts and maximum family benefits contained in this section in December 1978 shall be revised as provided by subsection (i) for each year after 1978.”.

(2) COMPUTATION OF PRIMARY INSURANCE BENEFIT UNDER 1939 ACT.—

(A) DIVISION OF WAGES BY ELAPSED YEARS.—Section 215(d)(1) (42 U.S.C. 415(d)(1)) is amended—

(i) in subparagraph (A), by inserting “and subject to section 104(j)(2) of the Social Security Amendments of 1972” after “thereof”; and

(ii) by striking “(B) For purposes” in subparagraph (B) and all that follows through clause (ii) of such subparagraph and inserting the following:

“(B) For purposes of subparagraphs (B) and (C) of subsection (b)(2) (as so in effect)—

“(i) the total wages prior to 1951 (as defined in subparagraph (C) of this paragraph) of an individual—

“(I) shall, in the case of an individual who attained age 21 prior to 1950, be divided by the number of years (hereinafter in this subparagraph referred to as the ‘divisor’) elapsing after the year in which the individual attained age 20, or 1936 if later, and prior to the earlier of the year of death or 1951, except that such divisor shall not include any calendar year entirely included in a period of disability, and in no case shall the divisor be less than one, and

“(II) shall, in the case of an individual who died before 1950 and before attaining age 21, be divided by the number of years (hereinafter in this subparagraph referred to as the ‘divisor’) elapsing after the second year prior to the year of death, or 1936 if later, and prior to the year of death, and in no case shall the divisor be less than one; and

“(ii) the total wages prior to 1951 (as defined in subparagraph (C) of this paragraph) of an individual who either attained age 21 after 1949 or died after 1949 before attaining age 21, shall be divided by the number of years (hereinafter in this subparagraph referred to as the ‘divisor’) elapsing after 1949 and prior to 1951.”

(B) CREDITING OF WAGES TO YEARS.—Clause (iii) of section 215(d)(1)(B) (42 U.S.C. 415(d)(1)(B)(iii)) is amended to read as follows:

“(iii) if the quotient exceeds \$3,000, only \$3,000 shall be deemed to be the individual’s wages for each of the years which were used in computing the amount of the divisor, and the remainder of the individual’s total wages prior to 1951 (I) if less than \$3,000, shall be deemed credited to the computation base year (as defined in subsection (b)(2) as in effect in December 1977) immediately preceding the earliest year used in computing the amount of the divisor, or (II) if \$3,000 or more, shall be deemed credited, in \$3,000 increments, to the computation base year (as so defined) immediately preceding the earliest year used in computing the amount of the divisor and to each of the computation base years (as so defined) consecutively preceding that year, with any remainder less than \$3,000 being credited to the computation base year (as so defined) immediately preceding the earliest year to which a full \$3,000 increment was credited; and”

(C) APPLICABILITY.—Section 215(d) is further amended—

(i) in paragraph (2)(B), by striking “except as provided in paragraph (3),”;

(ii) by striking paragraph (2)(C) and inserting the following:

“(C)(i) who becomes entitled to benefits under section 202(a) or 223 or who dies, or

“(ii) whose primary insurance amount is required to be recomputed under paragraph (2), (6), or (7) of subsection (f) or under section 231.”; and

(iii) by striking paragraphs (3) and (4).

(3) CONFORMING AMENDMENTS.—

(A) Section 215(i)(4) (42 U.S.C. 415(i)(4)) is amended in the first sentence by inserting “and as amended by section 5117

of the Omnibus Budget Reconciliation Act of 1990” after “as then in effect”.

(B) Section 203(a)(8) (42 U.S.C. 403(a)(8)) is amended in the first sentence by inserting “and as amended by section 5117 of the Omnibus Budget Reconciliation Act of 1990,” after “December 1978” the second place it appears.

(C) Section 215(c) (42 U.S.C. 415(c)) is amended by striking “This” and inserting “Subject to the amendments made by section 5117 of the Omnibus Budget Reconciliation Act of 1990, this”.

(D) Section 215(f)(7) (42 U.S.C. 415(f)(7)) is amended by striking the period at the end of the first sentence and inserting “, including a primary insurance amount computed under any such subsection whose operation is modified as a result of the amendments made by section 5117 of the Omnibus Budget Reconciliation Act of 1990”.

(E)(i) Section 215(d) (42 U.S.C. 415(d)) is further amended by redesignating paragraph (5) as paragraph (3).

(ii) Subsections (a)(7)(A), (a)(7)(C)(ii), and (f)(9)(A) of section 215 (42 U.S.C. 415) are each amended by striking “subsection (d)(5)” each place it appears and inserting “subsection (d)(3)”.

“(iii) Section 215(f)(9)(B) (42 U.S.C. 415(f)(9)(B)) is amended by striking “subsection (a)(7) or (d)(5)” each place it appears and inserting “subsection (a)(7) or (d)(3)”

(4) EFFECTIVE DATE.—

42 USC 403 note.

(A) **IN GENERAL.**—Except as provided in subparagraph (B), the amendments made by this subsection shall apply with respect to the computation of the primary insurance amount of any insured individual in any case in which a person becomes entitled to benefits under section 202 or 223 on the basis of such insured individual’s wages and self-employment income for months after the 18-month period following the month in which this Act is enacted, except that such amendments shall not apply if any person is entitled to benefits based on the wages and self-employment income of such insured individual for the month preceding the initial month of such person’s entitlement to such benefits under section 202 or 223.

(B) **RECOMPUTATIONS.**—The amendments made by this subsection shall apply with respect to any primary insurance amount upon the recomputation of such primary insurance amount if such recomputation is first effective for monthly benefits for months after the 18-month period following the month in which this Act is enacted.

(b) **BENEFITS IN CASE OF VETERANS.**—Section 217(b) (42 U.S.C. 417(b)) is amended—

(1) in the first sentence of paragraph (1), by striking “Any” and inserting “Subject to paragraph (3), any”; and

(2) by adding at the end the following new paragraph:

“(3)(A) The preceding provisions of this subsection shall apply for purposes of determining the entitlement to benefits under section 202, based on the primary insurance amount of the deceased World War II veteran, of any surviving individual only if such surviving individual makes application for such benefits before the end of the 18-month period after the month in which the Omnibus Budget Reconciliation Act of 1990 was enacted.

“(B) Subparagraph (A) shall not apply if any person is entitled to benefits under section 202 based on the primary insurance amount of such veteran for the month preceding the month in which such application is made.”

(c) **APPLICABILITY OF ALTERNATIVE METHOD FOR DETERMINING QUARTERS OF COVERAGE WITH RESPECT TO WAGES IN THE PERIOD FROM 1937 TO 1950.**—

(1) **APPLICABILITY WITHOUT REGARD TO NUMBER OF ELAPSED YEARS.**—Section 213(c) (42 U.S.C. 413(c)) is amended—

(A) by inserting “and 215(d)” after “214(a)”; and

(B) by striking “except where—” and all that follows and inserting the following: “except where such individual is not a fully insured individual on the basis of the number of quarters of coverage so derived plus the number of quarters of coverage derived from the wages and self-employment income credited to such individual for periods after 1950.”

42 USC 413 note.

(2) **APPLICABILITY WITHOUT REGARD TO DATE OF DEATH.**—Section 155(b)(2) of the Social Security Amendments of 1967 is amended by striking “after such date”.

42 USC 413 note.

(3) **EFFECTIVE DATE.**—The amendments made by this subsection shall apply only with respect to individuals who—

(A) make application for benefits under section 202 of the Social Security Act after the 18-month period following the month in which this Act is enacted, and

(B) are not entitled to benefits under section 227 or 228 of such Act for the month in which such application is made.

SEC. 5118. SUSPENSION OF DEPENDENT'S BENEFITS WHEN THE WORKER IS IN AN EXTENDED PERIOD OF ELIGIBILITY.

42 USC 423.

(a) **IN GENERAL.**—Section 223(e) (42 U.S.C. 623(e)) is amended by—

(1) by inserting “(1)” after “(e)”; and

(2) by adding at the end the following new paragraph:

“(2) No benefit shall be payable under section 202 on the basis of the wages and self-employment income of an individual entitled to a benefit under subsection (a)(1) of this section for any month for which the benefit of such individual under subsection (a)(1) is not payable under paragraph (1).”

42 USC 423 note.

(b) **EFFECTIVE DATE.**—The amendments made by subsection (a) shall apply with respect to benefits for months after the date of the enactment of this Act.

SEC. 5119. ENTITLEMENT TO BENEFITS OF DEEMED SPOUSE AND LEGAL SPOUSE.

(a) **CONTINUED ENTITLEMENT OF DEEMED SPOUSE DESPITE ENTITLEMENT OF LEGAL SPOUSE.**—Section 216(h)(1) (42 U.S.C. 416(h)(1)) is amended—

(1) in subparagraph (A)—

(A) by inserting “(i)” after “(h)(1)(A)”; and

(B) by striking “If such courts” in the second sentence and inserting the following:

“(ii) If such courts”; and

(2) in subparagraph (B)—

(A) by inserting “(i)” after “(B)”; and

(B) by striking “The provisions of the preceding sentence” in the second sentence and inserting the following:

“(ii) The provisions of clause (i)”; and

(C) by striking “(i) if another” in the second sentence and all that follows through “or (ii)”;

(D) by striking “The entitlement” in the third sentence and inserting the following:

“(iii) The entitlement”;

(E) by striking “subsection (b), (c), (e), (f), or (g)” the first place it appears in the third sentence and inserting “subsection (b) or (c)”;

(F) by striking “wife, widow, husband, or widower” the first place it appears in the third sentence and inserting “wife or husband”;

(G) by striking “(i) in which” in the third sentence and all that follows through “in which such applicant entered” and inserting “in which such person enters”;

(H) by striking “For purposes” in the fourth sentence and inserting the following:

“(iv) For purposes”;

and

(I) by striking “(i)” and “(ii)” in the fourth sentence and inserting “(I)” and “(II)”, respectively.

(b) TREATMENT OF DIVORCE IN THE CONTEXT OF INVALID MARRIAGE.—Section 216(h)(1)(B)(i) (as amended by subsection (a)) is further amended—

42 USC 416.

(1) by striking “where under subsection (b), (c), (f), or (g) such applicant is not the wife, widow, husband, or widower of such individual” and inserting “where under subsection (b), (c), (d), (f), or (g) such applicant is not the wife, divorced wife, widow, surviving divorced wife, husband, divorced husband, widower, or surviving divorced husband of such individual”;

(2) by striking “and such applicant” and all that follows through “files the application,”;

(3) by striking “subsections (b), (c), (f), and (g)” and inserting “subsections (b), (c), (d), (f), and (g)”;

(4) by adding at the end the following new sentences: “Notwithstanding the preceding sentence, in the case of any person who would be deemed under the preceding sentence a wife, widow, husband, or widower of the insured individual, such marriage shall not be deemed to be a valid marriage unless the applicant and the insured individual were living in the same household at the time of the death of the insured individual or (if the insured individual is living) at the time the applicant files the application. A marriage that is deemed to be a valid marriage by reason of the preceding sentence shall continue to be deemed a valid marriage if the insured individual and the person entitled to benefits as the wife or husband of the insured individual are no longer living in the same household at the time of the death of such insured individual.”.

(c) TREATMENT OF MULTIPLE ENTITLEMENTS UNDER THE FAMILY MAXIMUM.—Section 203(a)(3) (42 U.S.C. 403(a)(3)) is amended by adding after subparagraph (C) the following new subparagraph:

“(D) In any case in which—

“(i) two or more individuals are entitled to monthly benefits for the same month as a spouse under subsection (b) or (c) of section 202, or as a surviving spouse under subsection (e), (f), or (g) of section 202,

“(ii) at least one of such individuals is entitled by reason of subparagraph (A)(ii) or (B) of section 216(h)(1), and

“(iii) such entitlements are based on the wages and self-employment income of the same insured individual, the benefit of the entitled individual whose entitlement is based on a valid marriage (as determined without regard to subparagraphs (A)(ii) and (B) of section 216(h)(1)) to such insured individual shall, for such month and all months thereafter, be determined without regard to this subsection, and the benefits of all other individuals who are entitled, for such month or any month thereafter, to monthly benefits under section 202 based on the wages and self-employment income of such insured individual shall be determined as if such entitled individual were not entitled to benefits for such month.”.

(d) CONFORMING AMENDMENT.—Section 203(a)(6) (42 U.S.C. 403(a)(6)) is amended by inserting “(3)(D),” after “(3)(C),”.

42 USC 403 note.

(e) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall apply with respect to benefits for months after December 1990.

(2) APPLICATION REQUIREMENT.—

(A) GENERAL RULE.—Except as provided in subparagraph (B), the amendments made by this section shall apply only with respect to benefits for which application is filed with the Secretary of Health and Human Services after December 31, 1990.

(B) EXCEPTION FROM APPLICATION REQUIREMENT.—Subparagraph (A) shall not apply with respect to the benefits of any individual if such individual is entitled to a benefit under subsection (b), (c), (e), or (f) of section 202 of the Social Security Act for December 1990 and the individual on whose wages and self-employment income such benefit for December 1990 is based is the same individual on the basis of whose wages and self-employment income application would otherwise be required under subparagraph (A).

42 USC 1310
note.

SEC. 5120. VOCATIONAL REHABILITATION DEMONSTRATION PROJECTS.

(a) DEMONSTRATION PROJECT.—

(1) IN GENERAL.—Pursuant to section 505 of the Social Security Disability Amendments of 1980, the Secretary of Health and Human Services shall develop and carry out under this section demonstration projects in each of not fewer than three States. Each such demonstration project shall be designed to assess the advantages and disadvantages of permitting disabled beneficiaries (as defined in paragraph (3)) to select, from among both public and private qualified vocational rehabilitation providers, providers of vocational rehabilitation services directed at enabling such beneficiaries to engage in substantial gainful activity. Each such demonstration project shall commence as soon as practicable after the date of the enactment of this Act and shall remain in operation until the end of fiscal year 1993.

(2) SCOPE AND PARTICIPATION.—Each demonstration project shall be of sufficient scope and open to sufficient participation by disabled beneficiaries so as to permit meaningful determinations under subsection (b).

(3) DISABLED BENEFICIARY.—For purposes of this section, the term “disabled beneficiary” means an individual who is entitled to disability insurance benefits under section 223 of the Social

Security Act or benefits under section 202 of such Act based on such individual's own disability.

(b) **MATTERS TO BE DETERMINED.**—In the course of each demonstration project conducted under this section, the Secretary shall determine the following:

(1) the extent to which disabled beneficiaries participate in the process of selecting providers of rehabilitation services, and their reasons for participating or not participating;

(2) notable characteristics of participating disabled beneficiaries (including their impairments), classified by the type of provider selected;

(3) the various needs for rehabilitation demonstrated by participating disabled beneficiaries, classified by the type of provider selected;

(4) the extent to which providers of rehabilitation services which are not agencies or instrumentalities of States accept referrals of disabled beneficiaries under procedures in effect under section 222(d) of the Social Security Act as of the date of the enactment of this Act relating to reimbursement for such services and the most effective way of reimbursing such providers in accordance with such provisions;

(5) the extent to which providers participating in the demonstration projects enter into contracts with third parties for services and the types of such services;

(6) whether, and if so the extent to which, disabled beneficiaries who select their own providers of rehabilitation services are more likely to engage in substantial gainful activity and thereby terminate their entitlement under section 202 or 223 of the Social Security Act than those who do not;

(7) the cost effectiveness of permitting disabled beneficiaries to select their providers of vocational rehabilitation services, and the comparative cost effectiveness of different types of providers; and

(8) the feasibility of establishing a permanent national program for allowing disabled beneficiaries to choose their own qualified vocational rehabilitation provider and any additional safeguards which would be necessary to assure the effectiveness of such a program.

(c) **PROCEDURAL REQUIREMENTS.**—

(1) **SELECTION OF PARTICIPANTS.**—The Secretary shall select for participation in each demonstration project under this section disabled beneficiaries for whom there is a reasonable likelihood that rehabilitation services provided to them will result in performance by them of substantial gainful activity for a continuous period of nine months prior to termination of the project.

(2) **SELECTION OF PROVIDERS OF REHABILITATION SERVICES.**—The Secretary shall select qualified rehabilitation agencies to serve as providers of rehabilitation services in the geographic area covered by each demonstration project conducted under this section. The Secretary shall make such selection after consultation with disabled individuals and organizations representing such individuals. With respect to each demonstration project, the Secretary may approve on a case-by-case basis additional qualified rehabilitation agencies from outside the geographic area covered by the project to serve particular disabled beneficiaries.

(3) REIMBURSEMENT OF PROVIDERS.—

(A) Except as provided in subparagraph (B), providers of rehabilitation services under each demonstration project under this section shall be reimbursed in accordance with the procedures in effect under the provisions of section 222(d) of the Social Security Act as of the date of the enactment of this Act relating to reimbursement for services provided under such section.

(B) The Secretary may contract with providers of rehabilitation services under each demonstration project under this section on a fee-for-service basis in order to—

(i) conduct vocational evaluations directed at identifying those disabled beneficiaries who have reasonable potential for engaging in substantial gainful activity and thereby terminating their entitlement to benefits under section 202 or 223 of the Social Security Act if provided with vocational rehabilitation services as participants in the project, and

(ii) develop jointly with each disabled beneficiary so identified an individualized, written rehabilitation program.

(C) Each written rehabilitation program developed pursuant to subparagraph (B)(ii) for any participant shall include among its provisions—

(i) a statement of the participant's rehabilitation goal,

(ii) a statement of the specific rehabilitation services to be provided and of the identity of the provider to furnish such services,

(iii) the projected date for the initiation of such services and their anticipated duration, and

(iv) objective criteria and an evaluation procedure and schedule for determining whether the stated rehabilitation goal is being achieved.

(d) REPORTS.—The Secretary of Health and Human Services shall submit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate an interim written report on the progress of the demonstration projects conducted under this section not later than April 1, 1992, together with any related data and materials which the Secretary considers appropriate. The Secretary shall submit a final written report to such Committees addressing the matters to be determined under subsection (b) not later than April 1, 1994.

(e) STATE.—For purposes of this section, the term “State” means a State, including the entities included in such term by section 210(h) of the Social Security Act (42 U.S.C. 410(h)).

(f) CONTINUATION OF DEMONSTRATION AUTHORITY.—Section 505(c) of the Social Security Disability Amendments of 1980 (42 U.S.C. 1310 note) is amended to read as follows:

“(c) The Secretary shall submit to the Congress a final report with respect to all experiments and demonstration projects carried out under this section (other than demonstration projects conducted under section 5120 of the Omnibus Budget Reconciliation of 1990) no later than October 1, 1993.”.

SEC. 5121. EXEMPTION FOR CERTAIN ALIENS, RECEIVING AMNESTY UNDER THE IMMIGRATION AND NATIONALITY ACT, FROM PROSECUTION FOR MISREPORTING OF EARNINGS OR MISUSE OF SOCIAL SECURITY ACCOUNT NUMBERS OR SOCIAL SECURITY CARDS.

(a) **IN GENERAL.**—Section 208 (42 U.S.C. 408) is amended by adding at the end the following:

“(d)(1) Except as provided in paragraph (2), an alien—

“(A) whose status is adjusted to that of lawful temporary resident under section 210 or 245A of the Immigration and Nationality Act or under section 902 of the Foreign Relations Authorization Act, Fiscal Years 1988 and 1989,

“(B) whose status is adjusted to that of permanent resident—

“(i) under section 202 of the Immigration Reform and Control Act of 1986, or

“(ii) pursuant to section 249 of the Immigration and Nationality Act, or

“(C) who is granted special immigrant status under section 101(a)(27)(I) of the Immigration and Nationality Act,

shall not be subject to prosecution for any alleged conduct described in paragraph (6) or (7) of subsection (a) if such conduct is alleged to have occurred prior to 60 days after the date of the enactment of the Omnibus Budget Reconciliation Act of 1990.

“(2) Paragraph (1) shall not apply with respect to conduct (described in subsection (a)(7)(C)) consisting of—

“(A) selling a card that is, or purports to be, a social security card issued by the Secretary,

“(B) possessing a social security card with intent to sell it, or

“(C) counterfeiting a social security card with intent to sell it.

“(3) Paragraph (1) shall not apply with respect to any criminal conduct involving both the conduct described in subsection (a)(7) to which paragraph (1) applies and any other criminal conduct if such other conduct would be criminal conduct if the conduct described in subsection (a)(7) were not committed.”.

(b) **TECHNICAL AND CONFORMING AMENDMENTS.**—So much of section 208 as precedes subsection (d) (as added by subsection (a) of this section) is amended—

(1) in subsection (a), by redesignating paragraphs (1), (2), and (3) as subparagraphs (A), (B), and (C), respectively;

(2) in subsection (g), by redesignating paragraphs (1), (2), and (3) as subparagraphs (A), (B), and (C), respectively;

(3) by redesignating subsections (a) through (h) as paragraphs (1) through (8), respectively;

(4) by inserting “(a)” before “Whoever”;

(5) by inserting “(b)” at the beginning of the next-to-last undesignated paragraph; and

(6) by inserting “(c)” at the beginning of the last undesignated paragraph.

SEC. 5122. REDUCTION OF AMOUNT OF WAGES NEEDED TO EARN A YEAR OF COVERAGE APPLICABLE IN DETERMINING SPECIAL MINIMUM PRIMARY INSURANCE AMOUNT.

(a) **IN GENERAL.**—Section 215(a)(1)(C)(ii) (42 U.S.C. 415(a)(1)(C)(ii)) is amended by striking “of not less than 25 percent” the first place it appears and all that follows through “1977) if” and inserting “of not less than 25 percent (in the case of a year after 1950 and before 1978) of the maximum amount which (pursuant to subsection (e)) may be

counted for such year, or 25 percent (in the case of a year after 1977 and before 1991) or 15 percent (in the case of a year after 1990) of the maximum amount which (pursuant to subsection (e)) could be counted for such year if”.

(b) RETENTION OF CURRENT AMOUNT OF WAGES NEEDED TO EARN A YEAR OF COVERAGE FOR PURPOSES OF WINDFALL ELIMINATION PROVISION.—Section 215(a)(7)(D) (42 U.S.C. 415(a)(7)(D)) is amended—

(1) in the first sentence, by striking “(as defined in paragraph (1)(C)(ii))”; and

(2) by adding at the end (after the table) the following new flush sentence:

“For purposes of this subparagraph, the term ‘year of coverage’ shall have the meaning provided in paragraph (1)(C)(ii), except that the reference to ‘15 percent’ therein shall be deemed to be a reference to ‘25 percent’.”

SEC. 5123. CHARGING OF EARNINGS OF CORPORATE DIRECTORS.

(a) IN GENERAL.—

42 USC 411, 403.

(1) Title II is amended by moving the last undesignated paragraph of section 211(a) of such title (as added by section 9022(a) of the Omnibus Budget Reconciliation Act of 1987) to the end of section 203(f)(5) of such title.

42 USC 403.

(2) The undesignated paragraph moved to section 203(f)(5) of the Social Security Act by paragraph (1) is amended—

(A) by striking “Any income of an individual which results from or is attributable to” and inserting “(E) For purposes of this section, any individual’s net earnings from self-employment which result from or are attributable to”,

(B) by striking “the income is actually paid” and inserting “the income, on which the computation of such net earnings from self-employment is based, is actually paid”; and

(C) by striking “unless it was” and inserting “unless such income was”.

26 USC 1402.

42 USC 403 note.

(3) The last undesignated paragraph of section 1402(a) of the Internal Revenue Code of 1986 (as added by section 9022(b) of the Omnibus Budget Reconciliation Act of 1987) is repealed.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to income received for services performed in taxable years beginning after December 31, 1990.

SEC. 5124. COLLECTION OF EMPLOYEE SOCIAL SECURITY AND RAILROAD RETIREMENT TAXES ON TAXABLE GROUP-TERM LIFE INSURANCE PROVIDED TO RETIREES.

26 USC 3102.

(a) SOCIAL SECURITY TAXES.—Section 3102 of the Internal Revenue Code of 1986 (relating to deduction of tax from wages) is amended by adding at the end thereof the following new subsection:

“(d) SPECIAL RULE FOR CERTAIN TAXABLE GROUP-TERM LIFE INSURANCE BENEFITS.—

“(1) IN GENERAL.—In the case of any payment for group-term life insurance to which this subsection applies—

“(A) subsection (a) shall not apply,

“(B) the employer shall separately include on the statement required under section 6051—

“(i) the portion of the wages which consists of payments for group-term life insurance to which this subsection applies, and

“(ii) the amount of the tax imposed by section 3101 on such payments, and

“(C) the tax imposed by section 3101 on such payments shall be paid by the employee.

“(2) **BENEFITS TO WHICH SUBSECTION APPLIES.**—This subsection shall apply to any payment for group-term life insurance to the extent—

“(A) such payment constitutes wages, and

“(B) such payment is for coverage for periods during which an employment relationship no longer exists between the employee and the employer.”

(b) **RAILROAD RETIREMENT TAXES.**—Section 3202 of such Code (relating to deduction of tax from compensation) is amended by adding at the end thereof the following new subsection:

“(d) **SPECIAL RULE FOR CERTAIN TAXABLE GROUP-TERM LIFE INSURANCE BENEFITS.**—

“(1) **IN GENERAL.**—In the case of any payment for group-term life insurance to which this subsection applies—

“(A) subsection (a) shall not apply,

“(B) the employer shall separately include on the statement required under section 6051—

“(i) the portion of the compensation which consists of payments for group-term life insurance to which this subsection applies, and

“(ii) the amount of the tax imposed by section 3201 on such payments, and

“(C) the tax imposed by section 3201 on such payments shall be paid by the employee.

“(2) **BENEFITS TO WHICH SUBSECTION APPLIES.**—This subsection shall apply to any payment for group-term life insurance to the extent—

“(A) such payment constitutes compensation, and

“(B) such payment is for coverage for periods during which an employment relationship no longer exists between the employee and the employer.”

(c) **EFFECTIVE DATE.**—The amendments made by this section shall apply to coverage provided after December 31, 1990.

26 USC 3102
note.

SEC. 5125. TIER 1 RAILROAD RETIREMENT TAX RATES EXPLICITLY DETERMINED BY REFERENCE TO SOCIAL SECURITY TAXES.

(a) **TAX ON EMPLOYEES.**—Subsection (a) of section 3201 of the Internal Revenue Code of 1986 (relating to rate of tax) is amended—

26 USC 3201.

(1) by striking “following” and inserting “applicable”, and

(2) by striking “employee:” and all that follows and inserting “employee. For purposes of the preceding sentence, the term ‘applicable percentage’ means the percentage equal to the sum of the rates of tax in effect under subsections (a) and (b) of section 3101 for the calendar year.”

(b) **TAX ON EMPLOYEE REPRESENTATIVES.**—Paragraph (1) of section 3211(a) of such Code (relating to rate of tax) is amended—

(1) by striking “following” and inserting “applicable”, and

(2) by striking “representative:” and all that follows and inserting “representative. For purposes of the preceding sentence, the term ‘applicable percentage’ means the percentage equal to the sum of the rates of tax in effect under subsections (a) and (b) of section 3101 and subsections (a) and (b) of section 3111 for the calendar year.”

(c) **TAX ON EMPLOYERS.**—Subsection (a) of section 3221 of such Code (relating to rate of tax) is amended—

(1) by striking “following” and inserting “applicable”, and

(2) by striking “employer:” and all that follows and inserting “employer. For purposes of the preceding sentence, the term ‘applicable percentage’ means the percentage equal to the sum of the rates of tax in effect under subsections (a) and (b) of section 3111 for the calendar year.”

SEC. 5126. TRANSFER TO RAILROAD RETIREMENT ACCOUNT.

45 USC 231n
note.

Subsection (c)(1)(A) of section 224 of the Railroad Retirement Solvency Act of 1983 (relating to section 72(r) revenue increase transferred to certain railroad accounts) is amended by striking “1990” and inserting “1992”.

SEC. 5127. WAIVER OF 2-YEAR WAITING PERIOD FOR INDEPENDENT ENTITLEMENT TO DIVORCED SPOUSE’S BENEFITS.

(a) **WAIVER FOR PURPOSES OF DEDUCTIONS ON ACCOUNT OF WORK.**—Section 203(b)(2) (42 U.S.C. 403(b)(2)) is amended—

(1) by striking “(2) When” and all that follows through “2 years, the benefit” and inserting the following:

“(2)(A) Except as provided in subparagraph (B), in any case in which—

“(i) any of the other persons referred to in paragraph (1)(B) is entitled to monthly benefits as a divorced spouse under section 202(b) or (c) for any month, and

“(ii) such person has been divorced for not less than 2 years, the benefit”; and

(2) by adding at the end the following new subparagraph:

“(B) Clause (ii) of subparagraph (A) shall not apply with respect to any divorced spouse in any case in which the individual referred to in paragraph (1) became entitled to old-age insurance benefits under section 202(a) before the date of the divorce.”.

(b) **WAIVER IN CASE OF NONCOVERED WORK OUTSIDE THE UNITED STATES.**—Section 203(d)(1)(B) (42 U.S.C. 403(d)(1)(B)) is amended—

(1) by striking “(B) When” and all that follows through “2 years, the benefit” and inserting the following:

“(B)(i) Except as provided in clause (ii), in any case in which—

“(I) a divorced spouse is entitled to monthly benefits under section 202(b) or (c) for any month, and

“(II) such divorced spouse has been divorced for not less than 2 years, the benefit”; and

(2) by adding at the end the following new clause:

“(ii) Subclause (II) of clause (i) shall not apply with respect to any divorced spouse in any case in which the individual entitled to old-age insurance benefits referred to in subparagraph (A) became entitled to such benefits before the date of the divorce.”.

42 USC 403 note.

(c) **EFFECTIVE DATE.**—The amendments made by this section shall apply with respect to benefits for months after December 1990.

SEC. 5128. MODIFICATION OF THE PREEFFECTUATION REVIEW REQUIREMENT APPLICABLE TO DISABILITY INSURANCE CASES.

(a) **IN GENERAL.**—Section 221(c)(3) (42 U.S.C. 421(c)(3)) is amended to read as follows:

“(3)(A) In carrying out the provisions of paragraph (2) with respect to the review of determinations made by State agencies pursuant to

this section that individuals are under disabilities (as defined in section 216(i) or 223(d)), the Secretary shall review—

“(i) at least 50 percent of all such determinations made by State agencies on applications for benefits under this title, and

“(ii) other determinations made by State agencies pursuant to this section to the extent necessary to assure a high level of accuracy in such other determinations.

“(B) In conducting reviews pursuant to subparagraph (A), the Secretary shall, to the extent feasible, select for review those determinations which the Secretary identifies as being the most likely to be incorrect.

“(C) Not later than April 1, 1992, and annually thereafter, the Secretary shall submit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate a written report setting forth the number of reviews conducted under subparagraph (A)(ii) during the preceding fiscal year and the findings of the Secretary based on such reviews of the accuracy of the determinations made by State agencies pursuant to this section.”

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall apply with respect to determinations made by State agencies in fiscal years after fiscal year 1990. 42 USC 421 note.

SEC. 5129. RECOVERY OF OASDI OVERPAYMENTS BY MEANS OF REDUCTION IN TAX REFUNDS.

(a) **ADDITIONAL METHOD OF RECOVERY.**—Section 204(a)(1)(A) (42 U.S.C. 404(a)(1)(A)) is amended by inserting after “payments to such overpaid person,” the following: “or shall obtain recovery by means of reduction in tax refunds based on notice to the Secretary of the Treasury as permitted under section 3720A of title 31, United States Code,”.

(b) **RECOVERY BY MEANS OF REDUCTION IN TAX REFUNDS.**—Section 3720A of title 31, United States Code (relating to collection of debts owed to Federal agencies) is amended—

(1) in subsection (a), by striking “OASDI overpayment and”;

(2) by redesignating subsection (f) as subsection (g); and

(3) by inserting the following new subsection after subsection

(e):

“(f)(1) Subsection (a) shall apply with respect to an OASDI overpayment made to any individual only if such individual is not currently entitled to monthly insurance benefits under title II of the Social Security Act.

“(2)(A) The requirements of subsection (b) shall not be treated as met in the case of the recovery of an OASDI overpayment from any individual under this section unless the notification under subsection (b)(1) describes the conditions under which the Secretary of Health and Human Services is required to waive recovery of an overpayment, as provided under section 204(b) of the Social Security Act.

“(B) In any case in which an individual files for a waiver under section 204(b) of the Social Security Act within the 60-day period referred to in subsection (b)(2), the Secretary of Health and Human Services shall not certify to the Secretary of the Treasury that the debt is valid under subsection (b)(4) before rendering a decision on the waiver request under such section 204(b). In lieu of payment, pursuant to subsection (c), to the Secretary of Health and Human Services of the amount of any reduction under this subsection based

on an OASDI overpayment, the Secretary of the Treasury shall deposit such amount in the Federal Old-Age and Survivors Insurance Trust Fund or the Federal Disability Insurance Trust Fund, whichever is certified to the Secretary of the Treasury as appropriate by the Secretary of Health and Human Services.”.

(c) INTERNAL REVENUE CODE PROVISIONS.—

26 USC 6402.

(1) IN GENERAL.—Subsection (d) of section 6402 of the Internal Revenue Code of 1986 (relating to collection of debts owed to Federal agencies) is amended—

(A) in paragraph (1), by striking “any OASDI overpayment and”; and

(B) by striking paragraph (3) and inserting the following new paragraph:

“(3) TREATMENT OF OASDI OVERPAYMENTS.—

“(A) REQUIREMENTS.—Paragraph (1) shall apply with respect to an OASDI overpayment only if the requirements of paragraphs (1) and (2) of section 3720A(f) of title 31, United States Code, are met with respect to such overpayment.

“(B) NOTICE; PROTECTION OF OTHER PERSONS FILING JOINT RETURN.—

“(i) NOTICE.—In the case of a debt consisting of an OASDI overpayment, if the Secretary determines upon receipt of the notice referred to in paragraph (1) that the refund from which the reduction described in paragraph (1)(A) would be made is based upon a joint return, the Secretary shall—

“(I) notify each taxpayer filing such joint return that the reduction is being made from a refund based upon such return, and

“(II) include in such notification a description of the procedures to be followed, in the case of a joint return, to protect the share of the refund which may be payable to another person.

“(ii) ADJUSTMENTS BASED ON PROTECTIONS GIVEN TO OTHER TAXPAYERS ON JOINT RETURN.—If the other person filing a joint return with the person owing the OASDI overpayment takes appropriate action to secure his or her proper share of the refund subject to reduction under this subsection, the Secretary shall pay such share to such other person. The Secretary shall deduct the amount of such payment from amounts which are derived from subsequent reductions in refunds under this subsection and are payable to a trust fund referred to in subparagraph (C).

“(C) DEPOSIT OF AMOUNT OF REDUCTION INTO APPROPRIATE TRUST FUND.—In lieu of payment, pursuant to paragraph (1)(B), of the amount of any reduction under this subsection to the Secretary of Health and Human Services, the Secretary shall deposit such amount in the Federal Old-Age and Survivors Insurance Trust Fund or the Federal Disability Insurance Trust Fund, whichever is certified to the Secretary as appropriate by the Secretary of Health and Human Services.

“(D) OASDI OVERPAYMENT.—For purposes of this paragraph, the term ‘OASDI overpayment’ means any overpayment of benefits made to an individual under title II of the Social Security Act.”.

(2) **PRESERVATION OF REMEDIES.**—Subsection (e) of section 6402 of such Code (relating to review of reductions) is amended in the last sentence by inserting before the period the following: “or any such action against the Secretary of Health and Human Services which is otherwise available with respect to recoveries of overpayments of benefits under section 204 of the Social Security Act”.

- (d) **EFFECTIVE DATE.**—The amendments made by this section—
- (1) shall take effect January 1, 1991, and
 - (2) shall not apply to refunds to which the amendments made by section 2653 of the Deficit Reduction Act of 1984 (98 Stat. 1153) do not apply.

26 USC 6402
note.

SEC. 5130. MISCELLANEOUS TECHNICAL CORRECTIONS.

(a) IN GENERAL.—

(1) **AMENDMENT RELATING TO SECTION 7088 OF PUBLIC LAW 100-690.**—Section 208 (42 U.S.C. 408) is amended, in the last undesignated paragraph, by striking “section 405(c)(2) of this title” and inserting “section 205(c)(2)”.

(2) **AMENDMENTS RELATING TO SECTION 322 OF PUBLIC LAW 98-21.**—Paragraphs (1) and (2) of section 322(b) of the Social Security Amendments of 1983 (Public Law 98-21, 97 Stat. 121) are each amended by inserting “the first place it appears” before “the following”.

42 USC 411,
26 USC 1402.

(3) **AMENDMENT RELATING TO SECTION 1011B(b) (4) OF PUBLIC LAW 100-647.**—Section 211(a) (42 U.S.C. 411(a)) is amended by redesignating the second paragraph (14) as paragraph (15).

(4) **AMENDMENT RELATING TO SECTION 2003(d) OF PUBLIC LAW 100-647.**—Paragraph (3) of section 3509(d) of the Internal Revenue Code of 1986 (as amended by section 2003(d) of the Technical and Miscellaneous Revenue Act of 1988 (Public Law 100-647; 102 Stat. 3598)) is further amended by striking “subsection (d)(4)” and inserting “subsection (d)(3)”.

26 USC 3509.

(5) **AMENDMENT RELATING TO SECTION 10208 OF PUBLIC LAW 101-239.**—Section 209(a)(7)(B) (42 U.S.C. 409(a)(7)(B)) is amended by striking “subparagraph (B)” in the matter following clause (ii) and inserting “clause (ii)”

(b) **EFFECTIVE DATES.**—The amendments made by subsection (a) shall be effective as if included in the enactment of the provision to which it relates.

26 USC 1402
note.

TITLE VI—ENERGY AND ENVIRONMENTAL PROGRAMS

Subtitle A—Abandoned Mine Reclamation

SEC. 6001. SHORT TITLE.

This subtitle may be cited as the “Abandoned Mine Reclamation Act of 1990”

Abandoned
Mine
Reclamation Act
of 1990.
30 USC 1201
note.

SEC. 6002. ABANDONED MINE RECLAMATION FUND.

(a) **SOURCES OF DEPOSITS.**—Section 401(b) of the Surface Mining Control and Reclamation Act of 1977 (30 U.S.C. 1231(b)) is amended as follows:

- (1) Amend paragraph (1) to read as follows:

“(i) separates before October 1, 1990, and receives (or elects, in accordance with applicable provisions of this subchapter, to receive) a refund (described in paragraph (1)) which relates to a period of service ending before October 1, 1990;

“(ii) is entitled to an annuity under this subchapter (other than a disability annuity) which is based on service of such employee or Member, and which commences on or after December 2, 1990; and

“(iii) does not make the deposit (described in paragraph (1)) required in order to receive credit for the period of service with respect to which the refund relates.

“(B) Notwithstanding the second sentence of paragraph (1), the annuity to which an employee or Member under this paragraph is entitled shall (subject to adjustment under section 8340) be equal to an amount which, when taken together with the unpaid amount referred to in subparagraph (A)(iii), would result in the present value of the total being actuarially equivalent to the present value of the annuity which would otherwise be provided the employee or Member under this subchapter, as computed under subsections (a)-(i) and (n) of section 8339 (treating, for purposes of so computing the annuity which would otherwise be provided under this subchapter, the deposit referred to in subparagraph (A)(iii) as if it had been timely made).

“(C) The Office of Personnel Management shall prescribe such regulations as may be necessary to carry out this paragraph.”.

(2)(A) Section 8334 of title 5, United States Code, is amended in paragraphs (1) and (2) of subsection (e), and in subsection (h), by striking “(d),” and inserting “(d)(1),”.

(B) Section 8334(f) and section 8339(i)(1) of title 5, United States Code, are amended by striking “(d)” and inserting “(d)(1)”.

(C) Section 8339(e) of title 5, United States Code, is amended by striking “8334(d)” and inserting “8334(d)(1)”.

(D) The second sentence of section 8342(a) of title 5, United States Code, is amended by inserting “or 8334(d)(2)” after “8343a”.

(3) The amendments made by this subsection shall be effective with respect to any annuity having a commencement date later than December 1, 1990.

5 USC 8334 note.

SEC. 7002. REFORMS IN THE HEALTH BENEFITS PROGRAM.

(a) **HOSPITALIZATION-COST-CONTAINMENT MEASURES.**—Section 8902 of title 5, United States Code, is amended by adding at the end the following:

“(n) A contract for a plan described by section 8903 (1), (2), or (3), or section 8903a, shall require the carrier—

“(1) to implement hospitalization-cost-containment measures, such as measures—

“(A) for verifying the medical necessity of any proposed treatment or surgery;

“(B) for determining the feasibility or appropriateness of providing services on an outpatient rather than on an inpatient basis;

“(C) for determining the appropriate length of stay (through concurrent review or otherwise) in cases involving inpatient care; and

“(D) involving case management, if the circumstances so warrant; and

“(2) to establish incentives to encourage compliance with measures under paragraph (1).”.

(b) **IMPROVED CASH MANAGEMENT.**—Section 8909(a) of title 5, United States Code, is amended by adding at the end (as a flush left sentence) the following:

“Payments from the Fund to a plan participating in a letter-of-credit arrangement under this chapter shall, in connection with any payment or reimbursement to be made by such plan for a health service or supply, be made, to the maximum extent practicable, on a checks-presented basis (as defined under regulations of the Department of the Treasury).”.

(c) **EXEMPTION FROM STATE PREMIUM TAXES.**—Section 8909 of title 5, United States Code, is amended by adding at the end the following:

“(f)(1) No tax, fee, or other monetary payment may be imposed, directly or indirectly, on a carrier or an underwriting or plan administration subcontractor of an approved health benefits plan by any State, the District of Columbia, or the Commonwealth of Puerto Rico, or by any political subdivision or other governmental authority thereof, with respect to any payment made from the Fund.

“(2) Paragraph (1) shall not be construed to exempt any carrier or underwriting or plan administration subcontractor of an approved health benefits plan from the imposition, payment, or collection of a tax, fee, or other monetary payment on the net income or profit accruing to or realized by such carrier or underwriting or plan administration subcontractor from business conducted under this chapter, if that tax, fee, or payment is applicable to a broad range of business activity.”.

(d) **IMPROVED COORDINATION WITH MEDICARE.**—Section 8910 of title 5, United States Code, is amended by adding at the end the following:

“(d) The Office, in consultation with the Department of Health and Human Services, shall develop and implement a system through which the carrier for an approved health benefits plan described by section 8903 or 8903a will be able to identify those annuitants or other individuals covered by such plan who are entitled to benefits under part A or B of title XVIII of the Social Security Act in order to ensure that payments under coordination of benefits with Medicare do not exceed the statutory maximums which physicians may charge Medicare enrollees.”.

(e) **AMENDMENTS TO PUBLIC LAW 101-76.**—Public Law 101-76 (103 Stat. 556) is amended—

(1) in subsection (a)(1), by striking “contract year 1990 or 1991,” and inserting “each of contract years 1990 through 1993 (inclusive),”; and

(2) in subsection (c), by striking “contract year 1991,” and inserting “a contract year (or any period thereafter),”.

(f) **APPLICATION OF CERTAIN MEDICARE LIMITS TO FEDERAL EMPLOYEE HEALTH BENEFITS ENROLLEES AGE 65 OR OLDER.**—(1) Section 8904 of title 5, United States Code, is amended by inserting “(a)” before the first sentence and by adding at the end of the section the following new subsection:

“(b)(1) A plan, other than a prepayment plan described in section 8903(4) of this title, may not provide benefits, in the case of any retired enrolled individual who is age 65 or older and is not covered to receive Medicare hospital and insurance benefits under part A of title XVIII of the Social Security Act (42 U.S.C. 1395c et seq.), to pay

a charge imposed by any health care provider, for inpatient hospital services which are covered for purposes of benefit payments under this chapter and part A of title XVIII of the Social Security Act, to the extent that such charge exceeds applicable limitations on hospital charges established for Medicare purposes under section 1886 of the Social Security Act (42 U.S.C. 1395ww). Hospital providers who have in force participation agreements with the Secretary of Health and Human Services consistent with sections 1814(a) and 1866 of the Social Security Act (42 U.S.C. 1395f(a) and 1395cc), whereby the participating provider accepts Medicare benefits as full payment for covered items and services after applicable patient copayments under section 1813 of such Act (42 U.S.C. 1395e) have been satisfied, shall accept equivalent benefit payments and enrollee copayments under this chapter as full payment for services described in the preceding sentence. The Office of Personnel Management shall notify the Secretary of Health and Human Services if a hospital is found to knowingly and willfully violate this subsection on a repeated basis and the Secretary may invoke appropriate sanctions in accordance with section 1866(b)(2) of the Social Security Act (42 U.S.C. 1395cc(b)(2)) and applicable regulations.

“(2) Notwithstanding any other provision of law, the Secretary of Health and Human Services and the Director of the Office of Personnel Management, and their agents, shall exchange any information necessary to implement this subsection.

“(3)(A) Not later than December 1, 1991, and periodically thereafter, the Secretary of Health and Human Services (in consultation with the Director of the Office of Personnel Management) shall supply to carriers of plans described in paragraphs (1) through (3) of section 8903 the Medicare program information necessary for them to comply with paragraph (1).

“(B) For purposes of this paragraph, the term ‘Medicare program information’ includes the limitations on hospital charges established for Medicare purposes under section 1886 of the Social Security Act (42 U.S.C. 1395ww) and the identity of hospitals which have in force agreements with the Secretary of Health and Human Services consistent with section 1814(a) and 1866 of the Social Security Act (42 U.S.C. 1395f(a) and 1395cc).”

(2) The amendments made by this subsection shall apply with respect to contract years beginning on or after January 1, 1992. 5 USC 8904 note.

(g) EFFECTIVE DATE.—Except as provided in subsection (f), the amendments made by this section shall apply with respect to contract years beginning on or after January 1, 1991. 5 USC 8902 note.

Subtitle B—Postal Service

SEC. 7101. FUNDING OF COLAS FOR POSTAL SERVICE ANNUITANTS AND SURVIVOR ANNUITANTS.

(a) EXPANDED SCOPE OF COVERAGE; CHANGE IN PRORATION RULE.—Section 8348(m)(1) of title 5, United States Code, is amended by striking “October 1, 1986,” each place it appears and inserting “July 1, 1971,”.

(b) REPEAL OF PROVISION RELATING TO CERTAIN EARLIER COLAS.—Section 4002(b) of the Omnibus Budget Reconciliation Act of 1989 (Public Law 101-239; 103 Stat. 2134) is repealed.

(c) PROVISION RELATING TO PRE-1991 COLAS.—(1) For the purpose of this subsection— 5 USC 8348 note.

“§ 3205. Limitation on compensation payments for certain incompetent veterans

“(a) In any case in which a veteran having neither spouse, child, nor dependent parent is rated by the Secretary in accordance with regulations as being incompetent and the value of the veteran’s estate (excluding the value of the veteran’s home) exceeds \$25,000, further payment of compensation to which the veteran would otherwise be entitled may not be made until the value of such estate is reduced to less than \$10,000.

“(b)(1) Subject to paragraph (2) of this subsection, if a veteran denied payment of compensation pursuant to subsection (a) is subsequently rated as being competent, the Secretary shall pay to the veteran a lump sum equal to the total of the compensation which was denied the veteran pursuant to such paragraph. The Secretary shall make the lump-sum payment as soon as practicable after the end of the 90-day period beginning on the date of the competency rating.

“(2) A lump-sum payment may not be made under paragraph (1) to a veteran who, within such 90-day period, dies or is again rated by the Secretary as being incompetent.

“(3) The costs of administering this subsection shall be paid from amounts available to the Department of Veterans Affairs for the payment of compensation and pension.

“(c) This section expires on September 30, 1992.”

(2) The table of sections at the beginning of such chapter is amended by adding at the end the following new item:

“3205. Limitation on compensation payments for certain incompetent veterans.”

(b) **EFFECTIVE DATE.**—The amendment made by this section shall apply with respect to payment of compensation for months after October 1990.

SEC. 8002. ELIMINATION OF PRESUMPTION OF TOTAL DISABILITY IN DETERMINATION OF PENSION FOR CERTAIN VETERANS.

(a) **ELIMINATION OF PRESUMPTION.**—That portion of subsection (a) of section 502 of title 38, United States Code, preceding paragraph (1) is amended to read as follows:

“(a) For the purposes of this chapter, a person shall be considered to be permanently and totally disabled if such a person is unemployable as a result of disability reasonably certain to continue throughout the life of the disabled person, or is suffering from—”

(b) **APPLICABILITY.**—The amendment made by subsection (a) shall apply with respect to claims filed after October 31, 1990.

SEC. 8003. REDUCTION IN PENSION FOR CERTAIN VETERANS RECEIVING MEDICAID-COVERED NURSING HOME CARE.

(a) **IN GENERAL.**—Section 3203 of title 38, United States Code, is amended by adding at the end the following:

“(f)(1) For the purposes of this subsection—

“(A) the term ‘Medicaid plan’ means a State plan for medical assistance referred to in section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)); and

“(B) the term ‘nursing facility’ means a nursing facility described in section 1919 of such Act (42 U.S.C. 1396r).

“(2) If a veteran having neither spouse nor child is covered by a Medicaid plan for services furnished such veteran by a nursing facility, no pension in excess of \$90 per month shall be paid to or for

38 USC 3205
note.

38 USC 502 note.

the veteran for any period after the month of admission to such nursing facility.

“(3) Notwithstanding any provision of title XIX of the Social Security Act, the amount of the payment paid a nursing facility pursuant to a Medicaid plan for services furnished a veteran may not be reduced by any amount of pension permitted to be paid such veteran under paragraph (2) of this subsection.

“(4) A veteran is not liable to the United States for any payment of pension in excess of the amount permitted under this subsection that is paid to or for the veteran by reason of the inability or failure of the Secretary to reduce the veteran’s pension under this subsection unless such inability or failure is the result of a willful concealment by the veteran of information necessary to make a reduction in pension under this subsection.

“(5) The costs of administering this subsection shall be paid for from amounts available to the Department of Veterans Affairs for the payment of compensation and pension.

“(6) This subsection expires on September 30, 1992.”.

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall take effect on November 1, 1990, or the date of the enactment of this Act, whichever is later. 38 USC 3203 note.

SEC. 8004. INELIGIBILITY OF REMARRIED SURVIVING SPOUSES OR MARRIED CHILDREN FOR REINSTATEMENT OF BENEFITS ELIGIBILITY UPON BECOMING SINGLE.

(a) **IN GENERAL.**—Section 103 of title 38, United States Code, is amended—

(1) in subsection (d)—

(A) by striking out “(1)”; and

(B) by striking out paragraphs (2) and (3); and

(2) in subsection (e)—

(A) by striking out “(1)”; and

(B) by striking out paragraph (2).

(b) **EFFECTIVE DATE.**—The amendments made by subsection (a) shall apply with respect to claims filed after October 31, 1990, and shall not operate to reduce or terminate benefits to any individual whose benefits were predicated on section 103(d)(2), 103(d)(3), or 103(e)(2) before the effective date of those amendments. 38 USC 103 note.

SEC. 8005. COST-OF-LIVING INCREASES IN COMPENSATION RATES.

38 USC 301 note.

(a) **POLICY REGARDING FISCAL YEAR 1991.**—The fiscal year 1991 cost-of-living adjustments in the rates of compensation payable under chapter 11 of title 38, United States Code, and of the dependency and indemnity compensation payable under chapter 13 of such title will be no more than a 5.4 percent increase, with all increased monthly rates rounded down to the next lower dollar. The effective date for such adjustments will not be earlier than January 1, 1991.

(b) **INCREASE PAYABLE AS OF JANUARY 1992.**—The amount of compensation or dependency and indemnity compensation payable to any individual for the month of January 1992 who is entitled to such benefits as of January 1, 1992, shall be increased for such month by the amount equal to the amount of the monthly increase provided for that individual’s benefit level as of January 1, 1991, pursuant to the adjustments described in subsection (a).

SEC. 8053. REQUIREMENT FOR CLAIMANTS TO REPORT SOCIAL SECURITY NUMBERS; USES OF DEATH INFORMATION BY THE DEPARTMENT OF VETERANS AFFAIRS.

(a) **MANDATORY REPORTING OF SOCIAL SECURITY NUMBERS.**—Section 3001 of title 38, United States Code, is amended by adding at the end the following new subsection:

“(c)(1) Any person who applies for or is in receipt of any compensation or pension benefit under laws administered by the Secretary shall, if requested by the Secretary, furnish the Secretary with the social security number of such person and the social security number of any dependent or beneficiary on whose behalf, or based upon whom, such person applies for or is in receipt of such benefit. A person is not required to furnish the Secretary with a social security number for any person to whom a social security number has not been assigned.

“(2) The Secretary shall deny the application of or terminate the payment of compensation or pension to a person who fails to furnish the Secretary with a social security number required to be furnished pursuant to paragraph (1) of this subsection. The Secretary may thereafter reconsider the application or reinstate payment of compensation or pension, as the case may be, if such person furnishes the Secretary with such social security number.

“(3) The costs of administering this subsection shall be paid for from amounts available to the Department of Veterans Affairs for the payment of compensation and pension.”.

(b) **REVIEW OF DEPARTMENT OF HEALTH AND HUMAN SERVICES DEATH INFORMATION TO IDENTIFY DECEASED RECIPIENTS OF COMPENSATION AND PENSION BENEFITS.**—(1) Chapter 53 of title 38, United States Code, as amended by section 8051(b), is further amended by adding at the end the following new section:

“§ 3118. Review of Department of Health and Human Services death information

“(a) The Secretary shall periodically compare Department of Veterans Affairs information regarding persons to or for whom compensation or pension is being paid with information in the records of the Department of Health and Human Services relating to persons who have died for the purposes of—

“(1) determining whether any such persons to whom compensation and pension is being paid are deceased;

“(2) ensuring that such payments to or for any such persons who are deceased are terminated in a timely manner; and

“(3) ensuring that collection of overpayments of such benefits resulting from payments after the death of such persons is initiated in a timely manner.

“(b) The Department of Health and Human Services death information referred to in subsection (a) of this section is death information available to the Secretary from or through the Secretary of Health and Human Services, including death information available to the Secretary of Health and Human Services from a State, pursuant to a memorandum of understanding entered into by such Secretaries. Any such memorandum of understanding shall include safeguards to assure that information made available under it is not used for unauthorized purposes or improperly disclosed.”.

(2) The table of sections at the beginning of such chapter, as amended by section 8051(b), is further amended by adding at the end the following:

“3118. Review of Department of Health and Human Services death information.”.

TITLE IX—TRANSPORTATION

Subtitle A—Surface Transportation

SEC. 9001. SENSE OF CONGRESS THAT HIGHWAY USER TAXES SHOULD BE DEDICATED TO THE HIGHWAY TRUST FUND.

(a) FINDINGS.—Congress finds that—

(1) highway motor fuel taxes have in the past been dedicated to the Highway Trust Fund and used for the development of the surface transportation system;

(2) extraordinary budget pressures have led to consideration of the need for a temporary, 5-year highway motor fuels tax for deficit reduction;

(3) any portion of the new taxes deposited into the Highway Trust Fund shall be available to accommodate our country's vital transportation needs;

(4) adequate funding of transportation is a key component of a national strategy for economic growth; and

(5) use of the highway motor fuels taxes for deficit reduction should be temporary so that we can return as soon as possible to the dedicated user fee principle in order to ensure fairness to highway users and to ensure that needed transportation infrastructure improvements are made.

(b) SENSE OF CONGRESS.—It is the sense of Congress that—

(1) any increase in motor fuel excise taxes that are deposited in the Highway Trust Fund shall be available for surface transportation purposes;

(2) the Budget Resolutions for fiscal years 1991 through 1995 should accommodate the Nation's transportation needs and the section 302(a) allocations should provide budget authority and outlays attributable to the increase in deposits into the Highway Trust Fund as a result of any increases in motor fuels taxes through implementation of this Act;

(3) Congress reaffirms the principle that highway motor fuel taxes should be deposited in the Highway Trust Fund; and

(4) to the extent the highway motor fuel taxes are used for deficit reduction during the 5-year period beginning with fiscal year 1991, the Congress should return to the dedicated user fee principle as soon as possible but no later than the end of fiscal year 1995.

Subtitle B—Aviation Safety and Capacity Expansion

Aviation Safety and Capacity Expansion Act of 1990.

SEC. 9101. SHORT TITLE; TABLE OF CONTENTS.

(a) **SHORT TITLE.**—This subtitle may be cited as the “Aviation Safety and Capacity Expansion Act of 1990”

49 USC app. 2201 note.

(b) **TABLE OF CONTENTS.**—

- Sec. 9101. Short title; table of contents.
- Sec. 9102. Construction of firefighting training facilities.
- Sec. 9103. Declaration of policy.
- Sec. 9104. Airport improvement program.
- Sec. 9105. Airway improvement program.
- Sec. 9106. FAA operations.
- Sec. 9107. Operation and maintenance of aviation system.
- Sec. 9108. Weather service.
- Sec. 9109. Military airport program.
- Sec. 9110. Passenger facility charges.
- Sec. 9111. Reduction in airport improvement program apportionments for large and medium hub airports imposing passenger facility charges.
- Sec. 9112. Use of PFC reduced apportionment funds.
- Sec. 9113. Small community air service program.
- Sec. 9114. State block grant pilot program.
- Sec. 9115. Auxiliary flight service station program.
- Sec. 9116. Airport and airway improvements for the Virgin Islands.
- Sec. 9117. Engine condition monitoring systems.
- Sec. 9118. Procurement authority.
- Sec. 9119. Expanded east coast plan.
- Sec. 9120. Transfer of format of geodetic navigation information.
- Sec. 9121. Sensitive security information.
- Sec. 9122. Reports.
- Sec. 9123. Atlantic City airport.
- Sec. 9124. Natural disaster regulation.
- Sec. 9125. Flight takeoff or landing requirement for State taxation.
- Sec. 9126. Allocation of existing capacity at certain airports.
- Sec. 9127. Certificate transfers.
- Sec. 9128. Severability.
- Sec. 9129. Buy American.
- Sec. 9130. Prohibition against fraudulent use of "made in America" labels.
- Sec. 9131. Restrictions on contract awards.

SEC. 9102. CONSTRUCTION OF FIREFIGHTING TRAINING FACILITIES.

Section 503(a)(2) of the Airport and Airway Improvement Act of 1982 (49 U.S.C. App. 2202(a)(2)) is amended—

- (1) by striking "and" at the end of subparagraph (B);
- (2) by striking the period at the end of subparagraph (C) and inserting "; and"; and
- (3) by inserting after subparagraph (C) the following new subparagraph:

"(D) any acquisition of land for, or work involved to construct, a burn area training structure on or off the airport for the purpose of providing live fire drill training for aircraft rescue and firefighting personnel required to receive such training by a regulation of the Department of Transportation, including basic equipment and minimum structures to support such training in accordance with standards of the Federal Aviation Administration."

SEC. 9103. DECLARATION OF POLICY.

Section 502(a) of the Airport and Airway Improvement Act of 1982 (49 U.S.C. App. 2201(a)) is amended—

- (1) in paragraph (5) by inserting ", including as they may be applied between category and class of aircraft" after "discriminatory practices"; and
- (2) in paragraph (13) by inserting "and should not unjustly discriminate between categories and classes of aircraft" after "attempted".

SEC. 9104. AIRPORT IMPROVEMENT PROGRAM.

Section 505 of the Airport and Airway Improvement Act of 1982 (49 U.S.C. App. 2204) is amended—

- (1) in subsection (a) by striking “‘13,816,700,000” and inserting⁷² “\$13,916,700,000”; and
- (2) in subsection (b) by striking “September 30, 1987” and inserting “September 30, 1992”

SEC. 9105. AIRWAY IMPROVEMENT PROGRAM.

(a) **RENAMING OF AIRWAY PLAN.**—Section 504(b)(1) of the Airport and Airway Improvement Act of 1982 (49 U.S.C. App. 2203(b)(1)) is amended by inserting after the second sentence the following new sentence: “For fiscal year 1991 and thereafter, the revised plan shall be known as the ‘Airway Capital Investment Plan’.”

(b) **AIRWAY FACILITIES AND EQUIPMENT.**—The first sentence of section 506(a)(1) of such Act (49 U.S.C. App. 2205(a)(1)) is amended by striking “September 30, 1981,” and all that follows through the period and inserting the following: “September 30, 1990, aggregate amounts not to exceed \$2,500,000,000 for fiscal year 1991 and \$5,500,000,000 for the fiscal years ending before October 1, 1992.”

SEC. 9106. FAA OPERATIONS.

Section 106 of title 49, United States Code, is amended by adding at the end the following new subsection:

“(k) **AUTHORIZATION OF APPROPRIATIONS FOR OPERATIONS.**—There is authorized to be appropriated for operations of the Administration \$4,088,000,000 for fiscal year 1991 and \$4,412,600,000 for fiscal year 1992.”

SEC. 9107. OPERATION AND MAINTENANCE OF AVIATION SYSTEM.

(a) **ELIMINATION OF PENALTY.**—Section 506(c)(3)(B)(i) of the Airport and Airway Improvement Act of 1982 (49 U.S.C. App. 2205(c)(3)(B)(i)) is amended—

- (1) by inserting “and” after “1989”; and
- (2) by striking “\$3,770,000,000” and all that follows through “1992.”

(b) **FUNDING.**—Section 506(c) of such Act (49 U.S.C. App. 2205(c)) is amended by adding at the end the following new paragraph:

“(4) **FISCAL YEARS 1991-1992.**—The amount appropriated from the Trust Fund for the purposes of clauses (A) and (B) of paragraph (1) of this subsection for each of fiscal years 1991 and 1992 may not exceed—

“(A) 75 percent of the amount of funds made available under section 505, subsections (a) and (b) of this section, and section 106(k) of title 49, United States Code, for such fiscal year; less

“(B) the amount of funds made available under section 505 and subsections (a) and (b) of this section for such fiscal year.”

SEC. 9108. WEATHER SERVICE.

The second sentence of section 506(d) of the Airport and Airway Improvement Act of 1982 (49 U.S.C. App. 2205(d)) is amended—

- (1) by striking “and” the first place it appears and inserting a comma; and
- (2) by inserting before the period the following: “, \$34,521,000 for fiscal year 1991, and \$35,389,000 for fiscal year 1992”.

⁷² So in original. Probably should be ““\$13,916,700,000”; and”.

SEC. 9109. MILITARY AIRPORT PROGRAM.

(a) **DECLARATION OF POLICY.**—Section 502(a) of the Airport and Airway Improvement Act of 1982 (49 U.S.C. App. 2201(a)) is further amended—

- (1) by striking “and” at the end of paragraph (12);
- (2) by striking the period at the end of paragraph (13) and inserting “; and”; and
- (3) by adding at the end the following:
“(14) special emphasis should be placed on the conversion of appropriate former military air bases to civil use and on the identification and improvement of additional joint-use facilities.”.

49 USC app.
2207.

(b) **SET-ASIDE.**—Section 508(d) of such Act (49 U.S.C. App. 2204(d)) is amended by striking paragraph (5) and inserting the following:

“(5) **MILITARY AIRPORT SET-ASIDE.**—Not less than 1.5 percent of the funds made available under section 505 in each of fiscal years 1991 and 1992 shall be distributed during such fiscal year to sponsors of current or former military airports designated by the Secretary under subsection (f) for the purpose of developing current and former military airports to improve the capacity of the national air transportation system.

“(6) **REALLOCATION.**—If the Secretary determines that he will not be able to distribute the amount of funds required to be distributed under paragraph (1), (2), (3), (4), or (5) of this subsection for any fiscal year because the number of qualified applications submitted in compliance with this title is insufficient to meet such amount, the portion of such amount the Secretary determines will not be distributed shall be available for obligation during such fiscal year for other airports and for other purposes authorized by section 505 of this title.”.

49 USC app.
2207.

(c) **DESIGNATION OF FORMER MILITARY AIRPORTS.**—Section 508 of such Act is further amended by adding at the end the following new subsection:

“(f) **DESIGNATION OF CURRENT OR FORMER MILITARY AIRPORTS.**—

“(1) **DESIGNATION.**—The Secretary shall designate not more than 8 current or former military airports for participation in the grant program established under subsection (d)(5) and this subsection. At least 2 such airports shall be designated within 6 months after the date of the enactment of this subsection and the remaining airports shall be designated for participation no later than September 30, 1992.

“(2) **SURVEY.**—The Secretary shall conduct a survey of current and former military airports to identify which ones have the greatest potential to improve the capacity of the national air transportation system. The survey shall also identify the capital development needs of such airports in order to make them part of the national air transportation system and shall identify which capital development needs are eligible for grants under section 505. The survey shall be completed by September 30, 1991.

“(3) **LIMITATION.**—In selecting airports for participation in the program established under subsection (d)(5) and this subsection and in conducting the survey under paragraph (2), the Secretary shall consider only those current or former military airports whose conversion in whole or in part to civilian commercial or reliever airport as part of the national air transportation

system would enhance airport and air traffic control system capacity in major metropolitan areas and reduce current and projected flight delays.

“(4) PERIOD OF ELIGIBILITY.—An airport designated by the Secretary under this subsection shall remain eligible to participate in the program under subsection (d)(5) and this subsection for the 5 fiscal years following such designation. An airport that does not attain a level of enplaned passengers during such 5 fiscal year period which qualifies it as a small hub airport as defined as of January 1, 1990, or reliever airport may be redesignated by the Secretary for participation in the program for such additional fiscal years as may be determined by the Secretary.

“(5) ADDITIONAL FUNDING.—Notwithstanding the provisions of section 513(b), not to exceed \$5,000,000 per airport of the sums to be distributed at the discretion of the Secretary under section 507(c) for any fiscal year may be used by the sponsor of a current or former military airport designated by the Secretary under this subsection for construction, improvement, or repair of terminal building facilities, including terminal gates used by aircraft for enplaning and deplaning revenue passengers. Under no circumstances shall any gates constructed, improved, or repaired with Federal funding under this paragraph be subject to long-term leases for periods exceeding 10 years or majority in interest clauses.”.

SEC. 9110. PASSENGER FACILITY CHARGES.

Section 1113 of the Federal Aviation Act of 1958 (49 U.S.C. App. 1513) is amended—

(1) in subsection (a) by inserting “except as provided in subsection (e) and” before “except that”; and

(2) by adding at the end the following new subsection:

“(e) AUTHORITY FOR IMPOSITION OF PASSENGER FACILITY CHARGES.—

“(1) IN GENERAL.—Subject to the provisions of this subsection, the Secretary may grant a public agency which controls a commercial service airport authority to impose a fee of \$1.00, \$2.00, or \$3.00 for each paying passenger of an air carrier enplaned at such airport to finance eligible airport-related projects to be carried out in connection with such airport or any other airport which such agency controls. For purposes of this subsection, financing an eligible airport-related project includes making payments for debt service on bonds and other indebtedness incurred to carry out such project.

“(2) USE OF REVENUES AND RELATIONSHIP BETWEEN FEES AND REVENUES.—The Secretary may grant a public agency which controls a commercial service airport authority to impose a fee under this subsection to finance specific projects only if the Secretary finds, on the basis of an application submitted for such authority—

“(A) that the amount and duration of the proposed fee will result in revenues (including interest and other returns on such revenues) which do not exceed amounts necessary to finance the specific projects; and

“(B) that each of the specific projects is an eligible airport-related project which will—

“(i) preserve or enhance capacity, safety, or security of the national air transportation system,

“(ii) reduce noise resulting from an airport which is part of such system, or

“(iii) furnish opportunities for enhanced competition between or among air carriers.

“(3) **LIMITATION REGARDING PASSENGERS OF AIR CARRIERS RECEIVING ESSENTIAL AIR SERVICE COMPENSATION.**—If a passenger of an air carrier is being provided air service to an eligible point under section 419 for which compensation is being paid under such section, a public agency which controls any other airport may not impose a fee pursuant to this subsection for enplanement of such passenger with respect to such air service.

“(4) **LIMITATION REGARDING OBLIGATIONS.**—No fee may be imposed pursuant to this subsection for a project which is not approved by the Secretary under this subsection on or before September 30, 1992—

“(A) if, during fiscal years 1991 and 1992, the amount available for obligation, in the aggregate, under section 505 of Airport and Airway Improvement Act of 1982 is less than \$3,700,000,000; or

“(B)(i) if, during fiscal year 1991, the amount available for obligation, in the aggregate, under section 419 is less than \$26,600,000; or

“(ii) if, during fiscal year 1992, the amount available for obligation, in the aggregate, under section 419 is less than \$38,600,000.

“(5) **LINKAGE.**—The Secretary may not grant a public agency authority to impose a fee pursuant to this subsection unless the Secretary has—

“(A) issued a final rule establishing a program for reviewing airport noise and access restrictions on operations of Stage 2 and Stage 3 aircraft pursuant to section 9304(a) of the Airport Noise and Capacity Act of 1990; and

“(B) issued a notice of proposed rulemaking to consider more efficient allocation of existing capacity at high density airports under section 9126 of the Aviation Safety and Capacity Expansion Act of 1990.

“(6) **TWO ENPLANEMENTS PER TRIP LIMITATION.**—Enplaned passengers on whom a fee may be imposed by a public agency pursuant to this subsection include passengers of air carriers originating or connecting at the commercial service airport which the agency controls. A fee may not be collected pursuant to this subsection from a passenger with respect to any enplanement of such passenger, on a one-way trip and on a trip in each direction of a round trip, after the second enplanement for which a fee has been collected pursuant to this subsection from such passenger.

“(7) **AIR CARRIER RATES, FEES, AND CHARGES.**—

“(A) **TREATMENT OF FEE REVENUES.**—Revenues derived from fees collected pursuant to this subsection shall not be treated as airport revenues for the purpose of establishing a rate, fee, or charge pursuant to a contract between a public agency which controls a commercial service airport and an air carrier.

“(B) **CAPITAL COSTS.**—Except as provided by subparagraph (C), a public agency which controls a commercial service airport shall not include in its rate base by means of

depreciation, amortization, or any other method that portion of the capital costs of a project paid for using revenues derived from fees collected pursuant to this subsection for the purpose of establishing a rate, fee, or charge pursuant to a contract between such agency and an air carrier.

“(C) **FACILITIES FINANCED WITH FEE REVENUES.**—With respect to a project for terminal development, gates and related areas, or a facility which is occupied or utilized by 1 or more air carriers on an exclusive or preferential basis, the rates, fees, and charges payable by air carriers which use such facilities shall be no less than the rates, fees, and charges paid by carriers using similar facilities at the airport which were not financed using revenues derived from collection of a fee imposed pursuant to this subsection.

“(8) **EXCLUSIVITY OF AUTHORITY.**—No State or political subdivision or agency thereof which is not a public agency controlling a commercial service airport shall prohibit, limit, or regulate the imposition of fees by the public agency pursuant to this subsection, collection of such fees, or use of revenues derived therefrom. No contract between an air carrier and a public agency which controls a commercial service airport entered into before, on, or after the date of the enactment of this subsection shall impair the authority of the public agency to impose fees pursuant to this subsection and to use the revenues derived from such fees in accordance with this subsection.

“(9) **NONEXCLUSIVITY OF CONTRACTUAL AGREEMENTS.**—No project carried out through the use of a fee collected pursuant to this subsection may be subject to an exclusive long-term lease or use agreement of an air carrier, as defined by the Secretary by regulation. No lease or use agreement of an air carrier with respect to a project constructed or expanded through the use of such fee may restrict the public agency which controls the airport from funding, developing, or assigning new capacity at the airport with revenues derived from fees imposed pursuant to this subsection.

“(10) **COLLECTION AND HANDLING OF FEES BY AIR CARRIERS.**—The regulations issued by the Secretary to carry out this subsection shall—

“(A) require air carriers and their agents to collect fees imposed by public agencies pursuant to this subsection;

“(B) establish procedures regarding handling and remittance of the amounts so collected;

“(C) ensure that such amounts are promptly paid to the public agency for which they are collected less a uniform amount determined by the Secretary as reflecting average necessary and reasonable expenses (net of interest accruing to the air carrier and agent after collection and prior to remittance) incurred in the collection and handling of such fees; and

“(D) require that the amount of fees collected pursuant to this subsection with respect to any air transportation be noted on the ticket for such air transportation.

“(11) **APPLICATION PROCESS.**—

“(A) **SUBMISSION.**—A public agency which controls a commercial service airport and is interested in imposing a fee pursuant to this subsection shall submit to the Secretary an application for authority to impose such fee.

“(B) CONTENT.—An application submitted under this paragraph shall contain such information and be in such form as the Secretary may require by regulation.

“(C) OPPORTUNITY FOR CONSULTATION.—Before submission of an application under this paragraph, a public agency shall provide reasonable notice to, and an opportunity for consultation with, air carriers operating at the airport. The Secretary shall issue regulations which define reasonable notice and contain the following requirements at a minimum:

“(i) A public agency must provide written notice—

“(I) of individual projects being considered for funding through imposition of a fee pursuant to this subsection; and

“(II) of the date and location of a meeting to present such projects to air carriers operating at the airport.

“(ii) Not later than 30 days after the issuance of a written notice under clause (i), each air carrier operating at the airport must provide to the public agency written notice of receipt of such notice. Failure of an air carrier to provide such notice may be deemed as certification of agreement with the project by such air carrier under clause (iv).

“(iii) Not later than 45 days after the issuance of written notice under clause (i), the public agency must conduct a meeting to provide air carriers—

“(I) descriptions of projects;

“(II) justifications for projects; and

“(III) a detailed financial plan for projects.

“(iv) Not later than 30 days after the date of such meeting, each air carrier must provide the public agency with certification of agreement or disagreement with projects (or total plan for such projects). The failure of an air carrier to submit such certification shall be deemed as certification of agreement with the project by such air carrier. Any certification of disagreement shall contain the reasons for such disagreement. The absence of such reasons will void the certification of disagreement.

“(D) NOTICE AND OPPORTUNITY FOR COMMENT.—After receiving an application under this paragraph, the Secretary shall provide notice and an opportunity for comment by air carriers and other interested persons concerning such application.

“(E) APPROVAL.—A fee may only be imposed pursuant to this subsection if the Secretary approves an application granting authority for the imposition of such fee. Not later than 120 days after the date of receipt of such an application, the Secretary shall make a final decision regarding approval of such application.

“(12) RECORDKEEPING AND AUDITS.—

“(A) WITH RESPECT TO COLLECTION OF FEES.—The Secretary shall issue regulations requiring such recordkeeping and auditing of accounts maintained by an air carrier and any agency thereof which is collecting a fee imposed pursuant to this subsection and by the public agency which is

imposing such fee as may be necessary to ensure compliance with this subsection.

“(B) WITH RESPECT TO USE OF REVENUES.—The Secretary shall periodically audit and review the use by a public agency which controls an airport of revenues derived from a fee imposed pursuant to this subsection. Upon such review and after a public hearing, the Secretary may terminate the authority of such agency to impose such fee, in whole or in part, to the extent the Secretary determines that revenues derived therefrom are not being used in accordance with this subsection.

“(C) SET-OFF.—If the Secretary determines that a fee imposed pursuant to this subsection is excessive or that the revenues derived from such fee are not being used in accordance with this subsection, the Secretary may set off such amounts as may be necessary to ensure compliance with this subsection against amounts otherwise payable to the public agency under the Airport and Airway Improvement Act of 1982.

“(13) TERMS AND CONDITIONS.—Authority granted to impose a fee pursuant to this subsection shall be subject to such terms and conditions as the Secretary may establish to carry out the objectives of this subsection.

“(14) ISSUANCE OF REGULATIONS.—Not later than 180 days after the date of the enactment of this subsection, the Secretary shall issue such regulations as may be necessary to carry out this subsection. Such regulations may prescribe the time and form by which a fee imposed pursuant to this subsection shall take effect.

“(15) DEFINITIONS.—For purposes of this subsection, the following definitions apply:

“(A) AIR CARRIER.—The term ‘air carrier’ includes a foreign air carrier.

“(B) AIRPORT, COMMERCIAL SERVICE AIRPORT, AND PUBLIC AGENCY.—The terms ‘airport’, ‘commercial service airport’, and ‘public agency’ have the meaning such terms have under section 503 of the Airport and Airway Improvement Act of 1982.

“(C) ELIGIBLE AIRPORT-RELATED PROJECT.—The term ‘eligible airport-related project’ means—

“(i) a project for airport development under the Airport and Airway Improvement Act of 1982;

“(ii) a project for airport planning under such Act;

“(iii) a project for terminal development described in section 513(b) of such Act;

“(iv) a project for airport noise capability planning under section 103(b) of the Aviation Safety and Noise Abatement Act of 1979;

“(v) a project to carry out noise compatibility measures which are eligible for assistance under section 104 of the Aviation Safety and Noise Abatement Act of 1979 without regard to whether or not a program has been approved for such measures under such section; and

“(vi) a project for construction of gates and related areas at which passengers are enplaned or deplaned.

“(D) SECRETARY.—The term ‘Secretary’ means the Secretary of Transportation.”.

SEC. 9111. REDUCTION IN AIRPORT IMPROVEMENT PROGRAM APPORTIONMENTS FOR LARGE AND MEDIUM HUB AIRPORTS IMPOSING PASSENGER FACILITY CHARGES.

Section 507(b) of the Airport and Airway Improvement Act of 1982 (49 U.S.C. App. 2206(b)) is amended by adding at the end the following new paragraph:

“(7) REDUCTION IN APPORTIONMENTS TO CERTAIN LARGE AND MEDIUM HUBS.—

“(A) GENERAL RULE.—The amount which, but for this paragraph, would be apportioned under this section (other than subsection (a)(2)) for a fiscal year to a sponsor of an airport that annually has 0.25 percent or more of the total annual enplanements in the United States and for which a fee is imposed in such fiscal year pursuant to section 1113(e) of the Federal Aviation Act of 1958 shall be reduced by an amount equal to 50 percent of the projected revenues derived from such fee in such fiscal year.

“(B) LIMITATIONS.—The maximum reduction in an apportionment to a sponsor of an airport as a result of this paragraph in a fiscal year shall be 50 percent of the amount which, but for this paragraph, would be apportioned to such airport under this section.”.

SEC. 9112. USE OF PFC REDUCED APPORTIONMENT FUNDS.

(a) ADDITION OF FUNDS TO EXISTING DISCRETIONARY FUND.—Section 507(c)(1) of the Airport and Airway Improvement Act of 1982 (49 U.S.C. App. 2206(c)(1)) is amended by inserting after the first sentence the following new sentences: “Twenty-five percent of the amounts which are not apportioned under this section as a result of subsection (b)(7) shall be added to such discretionary fund. Fifty percent of amounts added to such discretionary fund pursuant to the preceding sentence shall be used for making grants for projects at small hub airports (as such term is defined in section 419(k) of the Federal Aviation Act of 1958).”.

(b) SMALL AIRPORT FUND.—Section 507 of such Act is amended by redesignating subsections (d) and (e), and any references thereto, as subsections (e) and (f), respectively, and by inserting after subsection (c) the following new subsection:

“(d) SMALL AIRPORT FUND.—

“(1) ESTABLISHMENT.—Seventy-five percent of the amounts which are not apportioned under this section as a result of subsection (b)(7) shall constitute a small airport fund to be distributed at the discretion of the Secretary.

“(2) SET-ASIDE FOR GENERAL AVIATION AIRPORTS.—One-third of the amounts in the small airport fund established by this subsection and distributed by the Secretary under this subsection in a fiscal year shall be used for making grants to sponsors of public-use airports (other than commercial service airports) for any purpose for which funds are made available under section 505.

“(3) SET-ASIDE FOR NONHUB AIRPORTS.—Two-thirds of the amounts in the small airport fund established by this subsection and distributed by the Secretary under this subsection in a fiscal year shall be used for making grants to sponsors of

commercial service airports each of which annually has less than 0.05 percent of the total annual enplanements in the United States for any purpose for which funds are made available under section 505.

“(4) TREATMENT OF AIRPORTS PARTICIPATING IN STATE BLOCK PROGRAM.—An airport in a State which is participating in the State block grant program under section 534 shall be eligible to receive grants pursuant to this subsection to the same extent that the airport would be eligible to receive such grants if the State was not participating in such program.”.

(c) PROHIBITION ON REDUCED FUNDING.—It is the sense of Congress that the Secretary should not reduce funding under the discretionary fund established under section 507(c) of the Airport and Airway Improvement Act of 1982 for small commercial service and general aviation airports as a result of additional funds made available to such airports under this section, including amendments made by this section.

49 USC app.
2206 note.

SEC. 9113. SMALL COMMUNITY AIR SERVICE PROGRAM.

(a) DEFINITION OF ELIGIBLE POINT.—Section 419(a) of the Federal Aviation Act of 1958 (49 U.S.C. App. 1389(a)) is amended to read as follows:

“(a) ELIGIBLE POINT DEFINED.—

“(1) GENERAL RULE.—For purposes of this section, the term ‘eligible point’ means any point in the United States—

“(A) which was defined as an eligible point under this section as in effect before October 1, 1988;

“(B) which received scheduled air transportation at any time after January 1, 1990; and

“(C) which is not listed in the Department of Transportation Orders 89-9-37 and 89-12-52 as being a point no longer eligible for compensation under this section.

“(2) LIMITATION ON USE OF PER PASSENGER SUBSIDY.—The Secretary may not determine that a point described in paragraph (1) is not an eligible point on the basis of the per passenger subsidy at the point or on any other basis not specifically set forth in this section.”.

(b) FUNDING.—

(1) IN GENERAL.—Section 419 of such Act is amended by redesignating subsection (1), and any reference thereto, as subsection (m) and by inserting after subsection (k) the following new subsection:

“(1) FUNDING.—

“(1) CONTRACT AUTHORITY.—The Secretary is authorized to enter into agreements and to incur obligations from the Airport and Airway Trust Fund for the payment of compensation under this section. Approval by the Secretary of such an agreement shall be deemed a contractual obligation of the United States for payment of the Federal share of such compensation.

“(2) AMOUNTS AVAILABLE.—There shall be available to the Secretary from the Airport and Airway Trust Fund to incur obligations under this section \$38,600,000 per fiscal year for each of fiscal years 1992, 1993, 1994, 1995, 1996, 1997, and 1998. Such amounts shall remain available until expended.”.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect October 1, 1991.

49 USC app.
1389 note.

(c) **CONFORMING AMENDMENTS.**—Section 333 of Public Law 100-457 and section 325(a) of Public Law 101-164 are repealed.

SEC. 9114. STATE BLOCK GRANT PILOT PROGRAM.

Section 534 of the Airport and Airway Improvement Act of 1982 (49 U.S.C. App. 2227) is amended—

- (1) in subsection (a) by striking “1991” and inserting “1992”; and
- (2) in subsection (d) by striking “not later than 90 days before its scheduled termination” and inserting “not later than January 31, 1992”.

49 USC app.
1348 note.

SEC. 9115. AUXILIARY FLIGHT SERVICE STATION PROGRAM.

(a) **GENERAL RULE.**—The Secretary of Transportation shall develop and implement a system of manned auxiliary flight service stations. The auxiliary flight service stations shall supplement the services of the planned consolidation to 61 automated flight service stations under the flight service station modernization program. Auxiliary flight service stations shall be located in areas of unique weather or operational conditions which are critical to the safety of flight.

(b) **REPORT TO CONGRESS.**—Not later than 180 days after the date of the enactment of this Act, the Secretary of Transportation shall report to Congress with the plan and schedule for implementation of this section.

SEC. 9116. AIRPORT AND AIRWAY IMPROVEMENTS FOR THE VIRGIN ISLANDS.

(a) **AIR SPACE STUDY.**—The Administrator of the Federal Aviation Administration shall conduct an air space study of the Caribbean and Miami air traffic control regions for the purpose of determining methods of improving air safety and report to Congress the results of such study.

(b) **OPERATIONS OF AIRPORT TOWERS FOR ST. THOMAS AND ST. CROIX.**—The Administrator may not enter into contracts with private persons for operation of the airport control towers for St. Thomas and St. Croix, Virgin Islands, before the 30th day following the date on which a report is submitted to Congress under subsection (a).

(c) **REPLACEMENT OF RADAR FACILITIES FOR ST. THOMAS.**—The Administrator shall take such action as may be necessary to ensure that the radar facilities for the airport on St. Thomas, Virgin Islands, which were destroyed by Hurricane Hugo are replaced and operational by the 120th day following the date of the enactment of this Act.

SEC. 9117. ENGINE CONDITION MONITORING SYSTEMS.

(a) **STUDY.**—The Administrator of the Federal Aviation Administration shall conduct a study of the potential use of engine condition monitoring systems on aircraft. In conducting such study, the Administrator shall evaluate—

- (1) the availability of technology for such systems;
- (2) the capabilities of such systems in terms of enhancing safety and reducing maintenance costs associated with civil and military aircraft;

(3) the commercial viability of developing computer software to enable maintenance workers to efficiently use data gathered by such systems;

(4) the costs and benefits of using such systems as compared to engine fault detection methods which rely on the use of data relating to historical performance and statistical failure;

(5) the types of aircraft engine failures which may be prevented by using such systems; and

(6) the operational reliability of such systems.

(b) **REPORT TO CONGRESS.**—Not later than 12 months after the date of the enactment of this Act, the Administrator shall transmit to Congress a report containing the results of the study conducted pursuant to this section together with such legislative and administrative recommendations as the Administrator considers appropriate.

SEC. 9118. PROCUREMENT AUTHORITY.

(a) **IN GENERAL.**—Section 303 of the Federal Aviation Act of 1958 (49 U.S.C. App. 1344) is amended to read as follows:

“SEC. 303. PROCUREMENT AUTHORITY.

“(a) **ACQUISITION AND DISPOSAL OF PROPERTY.**—Subject to subsection (b), the Administrator, on behalf of the United States, is authorized, where appropriate—

“(1) within the limits of available appropriations made by the Congress therefor, to acquire by purchase, condemnation, lease for a term not to exceed 20 years, or otherwise, personal property or services and real property or interests therein, including, in the case of air navigation facilities (including airports) owned by the United States and operated under the direction of the Administrator, easements through or other interests in airspace immediately adjacent thereto and needed in connection therewith;

“(2) for adequate compensation, by sale, lease, or otherwise, to dispose of any real or personal property or interest therein; except that, other than for airport and airway property and technical equipment used for the special purposes of the Federal Aviation Administration, such disposition shall be made in accordance with the Federal Property and Administrative Services Act of 1949; and

“(3) to construct, improve, or renovate laboratories and other test facilities and to purchase or otherwise acquire real property required therefor.

“(b) **SPECIAL RULES FOR CERTAIN ACQUISITIONS.**—

“(1) **ACQUISITIONS BY CONDEMNATION.**—Any acquisition by condemnation under subsection (a) may be made in accordance with the provision of the Act of August 1, 1888 (40 U.S.C. 257; 25 Stat. 357), the Act of February 26, 1931 (40 U.S.C. 258a-258e-1; 46 Stat. 1421), or any other applicable Act; except that, in the case of condemnations of easements through or other interests in airspace, in fixing condemnation awards, consideration may be given to the reasonable probable future use of the underlying land.

“(2) **ACQUISITIONS OF PUBLIC BUILDINGS.**—The Administrator may, under subsection (a) construct or acquire by purchase, condemnation, or lease a public building, or interest in a public building (as defined in section 13 of the Public Buildings Act of

1959 (40 U.S.C. 612)) only under a delegation of authority from the Administrator of General Services.

“(c) **PROCUREMENT PROCEDURES.**—In procuring personal property or services and real property and interests therein under subsection (a), the Administrator may use procedures other than competitive procedures in circumstances which are set forth in section 303(c) of the Federal Property and Administrative Services Act of 1949 (41 U.S.C. 253(c)).

“(d) **SOLE SOURCE APPROVAL BY ADMINISTRATOR.**—For procurements by the Federal Aviation Administration, the Administrator shall be the senior procurement executive referred to in paragraph (3) of section 16 of Office of Federal Procurement Policy Act (41 U.S.C. 414) for the purposes of approving the justification for the use of noncompetitive procedures required under section 303(f)(1)(B)(iii) of the Federal Property and Administrative Services Act of 1949 (41 U.S.C. 253(f)(1)(B)(iii)).

“(e) **MULTIYEAR SERVICE CONTRACTS.**—

“(1) **IN GENERAL.**—Notwithstanding section 1341(a)(1)(B) of title 31, United States Code, the Administrator may enter into contracts for periods of not more than 5 years for the following types of services (and items of supply related to such services) for which funds would otherwise be available for obligation only within the fiscal year for which appropriated—

“(A) operation, maintenance, and support of facilities and installations;

“(B) operation, maintenance, or modification of aircraft, vehicles, and other highly complex equipment;

“(C) specialized training necessitating high quality instructor skills (for example, pilot and aircrew members; foreign language training); and

“(D) base services (for example, ground maintenance, in-plane refueling; bus transportation; refuse collection and disposal).

“(2) **FINDINGS.**—The Administrator may enter into a contract described in paragraph (1) only if the Administrator finds that—

“(A) there will be a continuing requirement for the services consonant with current plans for the proposed contract period;

“(B) the furnishing of such services will require a substantial initial investment in plant or equipment, or the incurrence of substantial contingent liabilities for the assembly, training, or transportation of a specialized workforce; and

“(C) the use of such a contract will promote the best interests of the United States by encouraging effective competition and promoting economies in operation.

“(3) **GUIDANCE PRINCIPLES.**—In entering into contracts described in paragraph (1), the Administrator shall be guided by the following principles:

“(A) The portion of the cost of any plant or equipment amortized as a cost of contract performance should not exceed the ratio between the period of contract performance and the anticipated useful commercial life of such plant or equipment. Useful commercial life, for this purpose, means the commercial utility of the facilities rather than the physical life thereof, the due consideration given

to such factors as location of facilities, specialized nature thereof, and obsolescence.

“(B) Consideration shall be given to the desirability of obtaining an option to renew the contract for a reasonable period not to exceed 3 years, at prices not to include charges for plant, equipment, and other nonrecurring costs, already amortized.

“(C) Consideration shall be given to the desirability of reserving in the Federal Aviation Administration the right, upon payment of the unamortized portion of the cost of the plant or equipment, to take title thereto under appropriate circumstances.

“(4) TERMINATION.—In the event funds are not made available for the continuation of a contract described in paragraph (1) into a subsequent fiscal year, the contract shall be canceled or terminated, and the costs of cancellation or termination may be paid from—

“(A) appropriations originally available for the performance of the contract concerned;

“(B) appropriations currently available for procurement of the type of services concerned, and not otherwise obligated; or

“(C) funds appropriated for those payments.

“(f) MULTIYEAR PROPERTY ACQUISITION CONTRACTS.—

“(1) IN GENERAL.—Notwithstanding section 1341(a)(1)(B) of title 31, United States Code, to the extent that funds are otherwise available for obligation, the Administrator may make multiyear contracts (other than contracts described in paragraph (6)) for the purchase of property, whenever the Administrator finds—

“(A) that the use of such a contract will promote the safety or efficiency of the National Airspace System and will result in reduced total costs under the contract;

“(B) that the minimum need for the property to be purchased is expected to remain substantially unchanged during the contemplated contract period in terms of production rate, procurement rate, and total quantities;

“(C) that there is a reasonable expectation that throughout the contemplated contract period the Administrator will request funding for the contract at the level required to avoid contract cancellation;

“(D) that there is a stable design for the property to be acquired and that the technical risks associated with such property are not excessive; and

“(E) that the estimates of both the cost of the contract and the anticipated cost avoidance through the use of a multiyear contract are realistic.

“(2) REGULATIONS.—

“(A) GENERAL RULE.—The Administrator shall issue regulations for acquisition of property under this subsection to promote the use of multiyear contracting as authorized by paragraph (1) in a manner that will allow the most efficient use of multiyear contracting.

“(B) CANCELLATION PROVISIONS.—The regulations issued under this paragraph may provide for cancellation provisions in multiyear contracts described in paragraph (1) to the extent that such provisions are necessary and in the

best interests of the United States. Such cancellation provisions may include consideration of both recurring and nonrecurring costs of the contractor associated with the production of the items to be delivered under the contract.

“(C) BROADENING INDUSTRIAL BASE.—In order to broaden the aviation industrial base, the regulations issued under this paragraph shall provide that, to the extent practicable—

“(i) multiyear contracting under paragraph (1) shall be used in such a manner as to seek, retain, and promote the use under such contracts of companies that are subcontractors, vendors, or suppliers; and

“(ii) upon accrual of any payment or other benefit under such a multiyear contract to any subcontract, vendor, or supplier company participating in such contractor, such payment or benefit shall be delivered to such company in the most expeditious manner practicable.

“(D) PROTECTION OF FEDERAL INTERESTS.—The regulations issued under this paragraph shall also provide that, to the extent practicable, the administration of this subsection, and of the regulations issued under this subsection, shall not be carried out in a manner to preclude or curtail the existing ability of the Federal Aviation Administration to—

“(i) provide for competition in the production of items to be delivered under such a contract; or

“(ii) provide for termination of a prime contract the performance of which is deficient with respect to cost, quality, or schedule.

“(3) SPECIAL RULE FOR CONTRACTS WITH HIGH CANCELLATION CEILING.—Before any contract described in paragraph (1) that contains a clause setting forth a cancellation ceiling in excess of \$100,000,000 may be awarded, the Administrator shall give written notification of the proposed contract and of the proposed cancellation ceiling for that contract to the Committee on Commerce, Science, and Transportation of the Senate and the Committee on Public Works and Transportation of the House of Representatives, and such contract may not then be awarded until the end of a period of 30 days beginning on the date of such notification.

“(4) ADVANCE PROCUREMENT.—Contracts made under this subsection may be used for the advance procurement of components, parts, and materials necessary to the manufacture of equipment to be used in the National Airspace System, and contracts may be made under this subsection for such advance procurement, if feasible and practicable, in order to achieve economic-lot purchases and more efficient production rates.

“(5) TERMINATION.—In the event funds are not made available for the continuation of a contract made under this subsection into a subsequent fiscal year, the contract shall be canceled or terminated, and the costs of cancellation or termination may be paid from—

“(A) appropriations originally available for the performance of the contract concerned;

“(B) appropriations currently available for procurement of the type of property concerned, and not otherwise obligated; or

“(C) funds appropriated for those payments.

“(6) **LIMITATION ON APPLICABILITY.**—This subsection does not apply to contracts for the construction, alteration, or major repair or improvements to real property or contracts for the purchase of property to which section 111 of the Federal Property and Administrative Services Act of 1949 (40 U.S.C. 759) applies.

“(7) **MULTIYEAR CONTRACT DEFINED.**—For the purposes of this subsection, a multiyear contract is a contract for the purchase of property or services for more than 1, but not more than 5, fiscal years. Such a contract may provide that performance under the contract during the second and subsequent years of the contract is contingent upon the appropriation of funds and (if it does so provide) may provide for a cancellation payment to be made to the contractor if such appropriations are not made.

“(8) **PRICE OPTIONS.**—The Administrator may incorporate into a proposed multiyear contract negotiated priced options for varying the quantities of end items to be procured over the period of the contract.”.

(b) **CONFORMING AMENDMENT.**—The portion of the table of contents contained in the first section of such Act relating to section 303 is amended to read as follows:

“Sec. 303. Procurement authority.

“(a) Acquisition and disposal of property.

“(b) Special rules for acquisitions.

“(c) Procurement procedures.

“(d) Sole source approval by Administrator.

“(e) Multiyear service contracts.

“(f) Multiyear property acquisition contracts.”.

SEC. 9119. EXPANDED EAST COAST PLAN.

(a) **ENVIRONMENTAL IMPACT STATEMENT.**—Not later than 180 days after the date of the enactment of this Act, the Administrator of the Federal Aviation Administration shall issue an environmental impact statement pursuant to the National Environmental Policy Act of 1969 on the effects of changes in aircraft flight patterns over the State of New Jersey caused by implementation of the Expanded East Coast Plan.

(b) **AIR SAFETY INVESTIGATION.**—Not later than 180 days after the date of the enactment of this Act, the Administrator shall conduct an investigation to determine the effects on air safety of changes in aircraft flight patterns over the State of New Jersey caused by implementation of the Expanded East Coast Plan.

(c) **REPORT TO CONGRESS.**—Not later than 180 days after the date of the enactment of this Act, the Administrator shall transmit to Congress a report containing the results of the environmental impact statement and investigation conducted pursuant to this section. Such report shall also contain such recommendations for modification of the Expanded East Coast Plan as the Administrator considers appropriate or an explanation of why modification of such plan is not appropriate.

(d) **IMPLEMENTATION OF MODIFICATIONS.**—Not later than 1 year after the date of the enactment of this Act, the Administrator shall implement modifications to the Expanded East Coast Plan recommended under subsection (c).

SEC. 9120. TRANSFER OF FORMAT OF GEODETIC NAVIGATION INFORMATION.

Not later than 2 years after the date of the enactment of this Act, the Administrator of the Federal Aviation Administration and the Administrator of the National Oceanic and Atmospheric Administration shall complete the transfer of geodetic coordinate navigation information from NAD-27 format to NAD-83 format.

SEC. 9121. SENSITIVE SECURITY INFORMATION.

Section 316(d)(2) of the Federal Aviation Act of 1958 (49 U.S.C. App. 1357(d)(2)) is amended—

- (1) by inserting “security or” before “research and development activities”; and
- (2) by striking “subsection” and inserting “title”.

SEC. 9122. REPORTS.

Section 107 of the Federal Aviation Act of 1958 (49 U.S.C. App. 1307) is amended in subsections (b) and (c) by striking “each April 1 thereafter” each place it appears and inserting “through April 1, 1990”

SEC. 9123. ATLANTIC CITY AIRPORT.

Section 312 of the Airport and Airway Safety and Capacity Expansion Act of 1987 (101 Stat. 1528) is repealed.

SEC. 9124. NATURAL DISASTER REGULATION.

Title VI of the Federal Aviation Act of 1958 (49 U.S.C. App. 1421-1432) is amended by inserting after section 612 the following new section:

“SEC. 613. SAFETY REGULATION.

“(a) **NATIONAL DISASTER AREAS.**—Before the 180th day following the date of the enactment of this section, the Administrator, for safety and humanitarian reasons, shall issue such regulations as may be necessary to prohibit or otherwise restrict aircraft overflights of any inhabited area which has been declared a national disaster area in the State of Hawaii.

“(b) **EXCEPTIONS.**—Regulations issued pursuant to subsection (a) shall not be applicable in the case of aircraft overflights involving an emergency or a legitimate ⁷³ scientific purpose.

“(c) **STATUS OF STUDIES.**—Not later than the 90th day following the date of the enactment of this section, the Administrator shall report to Congress on the status of the studies and reports required by the Act entitled ‘An Act to require the Secretary of the Interior to conduct a study to determine the appropriate minimum altitude for aircraft flying over national airport system units’, approved August 18, 1987 (101 Stat. 674-678; 16 U.S.C. 1a-1 note).”.

SEC. 9125. FLIGHT TAKEOFF OR LANDING REQUIREMENT FOR STATE TAXATION.

Section 1113 of the Federal Aviation Act of 1958 (49 U.S.C. App. 1513) is amended by adding at the end the following new subsection:

“(f) **FLIGHT TAKEOFF OR LANDING REQUIREMENT FOR STATE TAXATION.**—No State (as such term is defined under subsection (d)(2)(E)) or political subdivision thereof shall levy or collect any tax on or with respect to any flight of a commercial aircraft or any activity or service on board such aircraft unless such aircraft takes off or lands in such State or political subdivision as part of such flight.”.

⁷³ So in original. Probably should be “legitimate”.

SEC. 9126. ALLOCATION OF EXISTING CAPACITY AT CERTAIN AIRPORTS.

(a) **RULEMAKING.**—The Secretary of Transportation shall, by July 1, 1991, initiate a rulemaking proceeding to consider more efficient methods of allocating existing capacity at high density traffic airports in order to provide improved opportunities for operations by new entrant air carriers.

(b) **DEFINITION.**—In this section, the term “new entrant air carrier”, as used with respect to a high density traffic airport, means an air carrier having less than 12 operating rights at such airport.

SEC. 9127. CERTIFICATE TRANSFERS.

Section 401(h) of the Federal Aviation Act of 1958 (49 App. U.S.C. 1371(h)) is amended—

(1) by inserting “(1)” after “(h)”; and

(2) by adding at the end the following new paragraphs:

“(2) **CERTIFICATION.**—The Secretary of Transportation shall, upon any transfer of a certificate, certify to the Committee on Commerce, Science, and Transportation of the Senate and the Committee on Public Works and Transportation of the House of Representatives that the transfer is consistent with the public interest.

“(3) **ACCOMPANYING REPORT.**—A certification under this subsection shall be accompanied by a report analyzing the effects of the transfer on—

“(A) the viability of each of the carriers involved in the transfer;

“(B) competition in the domestic airline industry,⁷⁴ and

“(C) the trade position of the United States in the international air transportation market.”.

SEC. 9128. SEVERABILITY.

If any provision of this subtitle (including an amendment made by this subtitle), or the application thereof to any person or circumstance, is held invalid, the remainder of this subtitle and the application of such provision to other persons or circumstances shall not be affected thereby.

49 USC app.
2201 note.

SEC. 9129. BUY AMERICAN.

(a) **GENERAL RULE.**—Notwithstanding any other provision of law, the Secretary of Transportation shall not obligate, after the date of enactment of this Act, any funds authorized to be appropriated to carry out this subtitle, section 106(k) of title 49, United States Code, or the Airport and Airway Improvement Act of 1982 (other than section 506(b)) for any project unless steel and manufactured products used in such project are produced in the United States.

(b) **LIMITATIONS ON APPLICABILITY.**—The provisions of subsection (a) of this section shall not apply where the Secretary finds—

(1) that their application would be inconsistent with the public interest;

(2) that such materials and products are not produced in the United States in sufficient and reasonably available quantities and of a satisfactory quality;

(3) in the case of the procurement of facilities and equipment under the Airport and Airway Improvement Act of 1982 that (A) the cost of components and subcomponents which are produced in the United States is more than 60 percent of the cost of all components of the facility or equipment described in this

49 USC app.
2226a.

⁷⁴ So in original. Probably should be “industry;”.

paragraph, and (B) final assembly of the facility or equipment described in this paragraph has taken place in the United States; or

(4) that inclusion of domestic material will increase the cost of the overall project contract by more than 25 percent.

(c) **CALCULATION OF COMPONENTS COSTS.**—For purposes of this section, in calculating components' costs, labor costs involved in final assembly shall not be included in the calculation.

49 USC app.
2226b.

SEC. 9130. PROHIBITION AGAINST FRAUDULENT USE OF "MADE IN AMERICA" LABELS.

If the Secretary of Transportation determines that any person intentionally affixes a label bearing a "Made in America" inscription to any product sold in or shipped to the United States that is not made in America, the Secretary shall declare that person ineligible to receive a Federal contract or grant in conjunction with the issuance of any contract made under this subtitle for a period of not less than 3 years and not more than 5 years. The Secretary may bring action against such person to enforce this subsection in any United States district court.

49 USC app.
2226c.

SEC. 9131. RESTRICTIONS ON CONTRACT AWARDS.

No person or enterprise domiciled or operating under the laws of a foreign government may enter into a contract or subcontract made pursuant to this subtitle if that government unfairly maintains, in government procurement, a significant and persistent pattern or practice of discrimination against United States products or services which results in identifiable harm to United States businesses, as identified by the President pursuant to section 305(g)(1)(A) of the Trade Agreements Act of 1979.

Federal Aviation
Administration
Research,
Engineering,
and
Development
Authorization
Act of 1990.
49 USC app.
2201 note.

Subtitle C—Federal Aviation Administration Research, Engineering, and Development

SEC. 9201. SHORT TITLE.

This subtitle may be cited as the "Federal Aviation Administration Research, Engineering, and Development Authorization Act of 1990".

SEC. 9202. AVIATION RESEARCH AUTHORIZATION OF APPROPRIATIONS.

Paragraph (2) of section 506(b) of the Airport and Airway Improvement Act of 1982 (49 U.S.C. App. 2205(b)(2)) is amended by striking subparagraph (A) and all that follows through the period at the end of such paragraph and inserting the following:

"(A) for fiscal year 1991—

"(i) \$135,800,000 solely for air traffic control projects and activities;

"(ii) \$19,100,000 solely for air traffic control advanced computer projects and activities;

"(iii) \$3,400,000 solely for navigation projects and activities;

"(iv) \$9,700,000 solely for aviation weather projects and activities;

"(v) \$16,500,000 solely for aviation medicine projects and activities;

“(vi) \$70,100,000 solely for aircraft safety projects and activities; and

“(vii) \$5,400,000 solely for environmental projects and activities; and

“(B) for fiscal year 1992—

“(i) \$135,800,000 solely for air traffic control projects and activities;

“(ii) \$19,100,000 solely for air traffic control advanced computer projects and activities;

“(iii) \$3,400,000 solely for navigation projects and activities;

“(iv) \$9,700,000 solely for aviation weather projects and activities;

“(v) \$16,500,000 solely for aviation medicine projects and activities;

“(vi) \$70,100,000 solely for aircraft safety projects and activities; and

“(vii) \$5,400,000 solely for environmental projects and activities.

Not less than 3 percent of the funds made available under this paragraph for a fiscal year shall be available to the Administrator for making grants under section 312(g) of the Federal Aviation Act of 1958.”

SEC. 9203. ENHANCED AIRPORT CAPACITY.

Section 506(b)(4) of the Airport and Airway Improvement Act of 1982 (49 U.S.C. 2205(b)(4)) is amended—

(1) in subparagraph (A) by striking “and 1990” and inserting “1990, 1991, and 1992”; and

(2) in subparagraph (B) by striking “and 1990” and inserting “1990, 1991, and 1992”.

SEC. 9204. WEATHER SERVICES.

Section 506(d) of the Airport and Airway Improvement Act of 1982 (49 U.S.C. App. 2205(d)) is amended by striking the second sentence and inserting the following: “Expenditures for the purposes of carrying out this subsection shall be limited to \$34,521,000 for fiscal year 1991 and \$35,389,000 for fiscal year 1992.”.

SEC. 9205. AVIATION RESEARCH GRANT PROGRAM.

(a) IN GENERAL.—Section 312 of the Federal Aviation Act of 1958 (49 U.S.C. App. 1353) is amended by adding the following new subsection:

“(g) RESEARCH GRANT PROGRAM.—

“(1) GENERAL AUTHORITY.—The Administrator may make grants to colleges, universities, and nonprofit research organizations to conduct aviation research into areas deemed by the Administrator to be required for the long-term growth of civil aviation.

“(2) APPLICATIONS.—A university, college, or nonprofit organization interested in receiving a grant under this subsection may submit to the Administrator an application for such grant. Such application shall be in such form and contain such information as the Administrator may require.

“(3) SELECTION.—The Administrator shall establish a solicitation, review, and evaluation process that ensures (A) the funding under this subsection of proposals having adequate merit

and relevancy to the mission of the Federal Aviation Administration, (B) an equitable geographical distribution of grant funds under this subsection, and (C) the inclusion of historically black colleges and universities and other minority institutions for funding consideration under this subsection.

“(4) RECORDS.—Each person awarded a grant under this subsection shall maintain such records as the Administrator may require as being necessary to facilitate an effective audit and evaluation of the use of grant funds.

“(5) REPORTS.—The Administrator shall make an annual report to the Committee on Science, Space, and Technology of the House of Representatives and the Committee on Commerce, Science, and Transportation of the Senate on the research grant program conducted under this subsection.”.

(b) CONFORMING AMENDMENT.—That portion of the table of contents contained in the first section of such Act which appears under the heading:

“Sec. 312. Development planning.”

is amended by adding at the end the following:

“(g) Research grant program.”.

SEC. 9206. STUDY BY THE GENERAL ACCOUNTING OFFICE OF MULTIYEAR CONTRACTING AUTHORITY.

The Comptroller General of the United States shall conduct a study of the advisability of granting to the Administrator of the Federal Aviation Administration specific statutory authority—

(1) to lease real property or interests therein for terms not to exceed 20 years, including, in the case of air navigation facilities and airports (as such terms are defined in section 101 (8) and (9) of the Federal Aviation Act of 1958) owned by the United States and operated under the direction of the Administrator, easements through or other interests in airspace immediately adjacent thereto and in connection therewith;

(2) to procure personal property or services and real property and interests therein with procedures other than competitive procedures under section 303(c) of the Federal Property and Administrative Services Act of 1949 (41 U.S.C. 253(c));

(3) to serve as the senior procurement executive under section 16 of the Office of Federal Procurement Policy Act (41 U.S.C. 414) for the purpose of approving the justification for the use of noncompetitive procedures required under section 303(f)(1)(B)(iii) of the Federal Property and Administrative Services Act of 1949 (41 U.S.C. 253(f)(1)(B)(iii));

(4) to let multiyear contracts for services, including the operation, maintenance, and support of facilities and installations; the operation, maintenance, and modification of aircraft, vehicles, and other highly complex equipment; specialized training necessitating high quality instructor skills; and base services; and

(5) to let multiyear contracts for the purchase of property.

The study also shall examine the implementation of section 2306(g) and (h) of title 10, United States Code, by the Department of Defense, and shall assess the usefulness of granting similar authority to the Federal Aviation Administration. The Comptroller General shall submit a report on the results of the study, along with any comments of the Administrator of the Federal Aviation Administra-

tion, to the Committee on Science, Space, and Technology of the House of Representatives and the Committee on Commerce, Science, and Transportation of the Senate within 6 months after the date of enactment of this Act.

SEC. 9207. BUY-AMERICAN REQUIREMENT.

49 USC app.
2226d.

(a) **DETERMINATION BY ADMINISTRATOR.**—If the Administrator, with the concurrence of the Secretary of Commerce and the United States Trade Representative, determines that the public interest so requires, the Administrator is authorized to award to a domestic firm a contract made pursuant to the issuance of any grant made under this subtitle that, under the use of competitive procedures, would be awarded to a foreign firm, if—

(1) the final product of the domestic firm will be completely assembled in the United States;

(2) when completely assembled, not less than 51 percent of the final product of the domestic firm will be domestically produced; and

(3) the difference between the bids submitted by the foreign and domestic firms is not more than 6 percent.

In determining under this subsection whether the public interest so requires, the Administrator shall take into account United States international obligations and trade relations.

(b) **LIMITED APPLICATION.**—This section shall not apply to the extent to which—

(1) such applicability would not be in the public interest;

(2) compelling national security considerations require otherwise; or

(3) the United States Trade Representative determines that such an award would be in violation of the General Agreement on Tariffs and Trade or an international agreement to which the United States is a party.

(c) **LIMITATION.**—This section shall apply only to contracts made related to the issuance of any grant made under this subtitle for which—

(1) amounts are authorized by this subtitle (including the amendments made by this subtitle) to be made available; and

(2) solicitations for bids are issued after the date of the enactment of this Act.

(d) **REPORT TO CONGRESS.**—The Administrator shall report to the Congress on contracts covered under this section and entered into with foreign entities in fiscal years 1991 and 1992 and shall report to the Congress on the number of contracts that meet the requirements of subsection (a) but which are determined by the United States Trade Representative to be in violation of the General Agreement on Tariffs and Trade or an international agreement to which the United States is a party. The Administrator shall also report to the Congress on the number of contracts covered under this subtitle (including the amendments made by this subtitle) and awarded based upon the parameters of this section.

(e) **DEFINITIONS.**—For purposes of this section—

(1) the term “Administrator” means the Administrator of the Federal Aviation Administration;

(2) the term “domestic firm” means a business entity that is incorporated in the United States and that conducts business operations in the United States; and

(3) the term “foreign firm” means a business entity not described in paragraph (2).

SEC. 9208. CATASTROPHIC FAILURE PREVENTION RESEARCH PROGRAM.

(a) **GENERAL AUTHORITY.**—Section 312(b) of the Federal Aviation Act of 1958 (49 U.S.C. App. 1353(b)) is amended by inserting after “inflight aircraft fires,” the following;⁷⁵ “to develop technologies and methods to assess the risk of and prevent defects, failures, and malfunctions of products, parts, processes, and articles manufactured for use in aircraft, aircraft engines, propellers, and appliances which could result in a catastrophic failure of an aircraft,”.

(b) **GRANT PROGRAM.**—Section 312 of such Act is amended by adding at the end the following new subsection:

“(h) **CATASTROPHIC FAILURE PREVENTION RESEARCH GRANT PROGRAM.**—

“(1) **GENERAL AUTHORITY.**—The Administrator may make grants to colleges, universities, and nonprofit research organizations (A) to conduct aviation research relating to development of technologies and methods to assess the risk and prevent defects, failures, and malfunctions of products, parts, processes, and articles manufactured for use in aircraft, aircraft engines, propellers, and appliances which could result in a catastrophic failure of an aircraft, and (B) to establish centers of excellence for continuing such research.

“(2) **SELECTION AND EVALUATION PROCESSES.**—The Administrator shall establish a solicitation, application, review, and evaluation process that ensures (A) the funding under this subsection of proposals having adequate merit and relevancy to the research described in paragraph (1).”.

(c) **CONFORMING AMENDMENT.**—That portion of the table of contents contained in the first section of such Act which appears under the heading:

“Sec. 312. Development planning.”

is amended by adding at the end the following:

“(h) Catastrophic failure prevention research grant program.”.

SEC. 9209. AVIATION RESEARCH AND CENTERS OF EXCELLENCE.

(a) **IN GENERAL.**—Section 312 of the Federal Aviation Act of 1958 (49 App. U.S.C. 1353) is amended by adding at the end the following new subsection:

“(i) **AVIATION RESEARCH AND CENTERS OF EXCELLENCE.**—

“(1) **GENERAL AUTHORITY.**—The Administrator may make grants to one or more colleges or universities to establish and operate several regional centers of air transportation excellence, whose locations shall be geographically equitable.

“(2) **RESPONSIBILITIES.**—The responsibilities of each regional center of air transportation excellence established under this subsection shall include, but not be limited to, the conduct of research concerning airspace and airport planning and design, airport capacity enhancement techniques, human performance in the air transportation environment, aviation safety and security, the supply of trained air transportation personnel including pilots and mechanics, and other aviation issues pertinent to developing and maintaining a safe and efficient air transportation system, and the interpretation, publication, and dissemination of the results of such research. In conducting such

⁷⁵ So in original. Probably should be “following.”.

research, each center may contract with nonprofit research organizations and other appropriate persons.

“(3) APPLICATION.—Any college or university interested in receiving a grant under this subsection shall submit to the Administrator an application in such form and containing such information as the Administrator may require by regulation.

“(4) SELECTION CRITERIA.—The Administrator shall select recipients of grants under this subsection on the basis of the following criteria:

“(A) The extent to which the needs of the State in which the applicant is located are representative of the needs of the region for improved air transportation services and facilities.

“(B) The demonstrated research and extension resources available to the applicant for carrying out this subsection.

“(C) The capability of the applicant to provide leadership in making national and regional contributions to the solution of both long-range and immediate air transportation problems.

“(D) The extent to which the applicant has an established air transportation program.

“(E) The demonstrated ability of the applicant to disseminate results of air transportation research and educational programs through a statewide or regionwide continuing education program.

“(F) The projects which the applicant proposes to carry out under the grant.

“(5) MAINTENANCE OF EFFORT.—No grant may be made under this subsection in any fiscal year unless the recipient of such grant enters into such agreements with the Administrator as the Administrator may require to ensure that such recipient will maintain its aggregate expenditures from all other sources for establishing and operating a regional center of air transportation excellence and related research activities at or above the average level of such expenditures in its 2 fiscal years preceding the date of enactment of this subsection.

“(6) FEDERAL SHARE.—The Federal share of a grant under this subsection shall be 50 percent of the costs of establishing and operating the regional center of air transportation excellence and related research activities carried out by the grant recipient.

“(7) ALLOCATION OF FUNDS.—Funds made available to carry out this subsection shall be allocated by the Administrator in a geographically equitable manner.”.

(b) RESEARCH ADVISORY COMMITTEE.—

(1) Section 312(f)(2) of the Federal Aviation Act of 1958 (49 App. U.S.C. 1353(f)(2)) is amended by adding at the end the following new sentence: “In addition, the committee shall review the research and training to be carried out by the regional centers of air transportation excellence established under subsection (h).”.

(2) Section 312(f)(3) of the Federal Aviation Act of 1958 (49 App. U.S.C. 1353(f)(3)) is amended—

(A) by striking “20” and inserting “30”; and

(B) by striking the last sentence and inserting the following: “The Administrator in appointing the members of the committee shall ensure that the research centers of air

transportation excellence, universities, corporations, associations, consumers, and other Government agencies are represented.”.

(c) **RESEARCH AUTHORITY OF ADMINISTRATOR.**—Section 312(c) of the Federal Aviation Act of 1958 (49 App. U.S.C. 1353(c)) is amended by inserting after the third sentence the following: “The Administrator shall undertake or supervise research programs concerning airspace and airport planning and design, airport capacity enhancement techniques, human performance in the air transportation environment, aviation safety and security, the supply of trained air transportation personnel including pilots and mechanics, and other aviation issues pertinent to developing and maintaining a safe and efficient air transportation system.”.

(d) **CONFORMING AMENDMENT.**—That portion of the table of contents contained in the first section of the Federal Aviation Act of 1958 relating to section 312 of that Act is amended by adding at the end the following:

“(i) Aviation research and centers of excellence.”

Airport Noise
and Capacity
Act of 1990.
49 USC app.
2151 note.

Subtitle D—Aviation Noise Policy

SEC. 9301. SHORT TITLE.

This subtitle may be cited as the “Airport Noise and Capacity Act of 1990”

49 USC app.
2151.

SEC. 9302. FINDINGS.

The Congress finds that—

- (1) aviation noise management is crucial to the continued increase in airport capacity;
- (2) community noise concerns have led to uncoordinated and inconsistent restrictions on aviation which could impede the national air transportation system;
- (3) a noise policy must be implemented at the national level;
- (4) local interest in aviation noise management shall be considered in determining the national interest;
- (5) community concerns can be alleviated through the use of new technology aircraft, combined with the use of revenues, including those available from passenger facility charges, for noise management;
- (6) federally controlled revenues can help resolve noise problems and carry with them a responsibility to the national airport system;
- (7) revenues derived from a passenger facility charge may be applied to noise management and increased airport capacity; and
- (8) a precondition to the establishment and collection of passenger facility charges is the issuance by the Secretary of Transportation of a final rule establishing procedures for reviewing airport noise and access restrictions on operations of Stage 2 and Stage 3 aircraft.

49 USC app.
2152.

SEC. 9303. NATIONAL AVIATION NOISE POLICY.

(a) **DEVELOPMENT.**—Not later than July 1, 1991, the Secretary of Transportation (hereinafter in this subtitle referred to as the “Secretary”) shall issue regulations establishing a national aviation noise policy which takes into account the findings, determinations,

and provisions of this subtitle, including the phaseout and nonaddition of Stage 2 aircraft as provided in this subtitle and implementation dates and reporting requirements consistent with this subtitle and existing law.

(b) **BASIS.**—The national aviation noise policy shall be based upon a detailed economic analysis of the impact of the phaseout date for Stage 2 aircraft on competition in the airline industry, including the ability of air carriers to achieve capacity growth consistent with the projected rate of growth for the airline industry, the impact of competition within the airline and air cargo industries, the impact on nonhub and small community air service, and the impact on new entry into the airline industry.

(c) **RECOMMENDATIONS.**—Not later than July 1, 1991, the Secretary shall transmit to Congress recommendations on—

(1) the need for changes in the standards and procedures which govern the rights of State and local governments (including airport authorities) to restrict aircraft operations for the purpose of limiting aircraft noise;

(2) the need for changes in the standards and procedures which govern law suits by persons adversely affected by aircraft noise;

(3) the need for changes in standards and procedures for Federal regulation of airspace (including the pattern of operations for the air traffic control system) in order to take better account of environmental effects;

(4) the need for changes in the Federal program providing assistance for noise abatement planning and programs, including the need for greater incentives or mandatory requirements for local restrictions on the use of land impacted by aircraft noise;

(5) whether any changes in policy recommended in paragraphs (1) through (4) should be accomplished through regulatory, administrative, or legislative action; and

(6) specific legislative proposals necessary for implementing the national aviation noise policy.

SEC. 9304. NOISE AND ACCESS RESTRICTION REVIEWS.

49 USC 2153.

(a) **IN GENERAL.**—

(1) **ESTABLISHMENT OF PROGRAM.**—The national aviation noise policy to be established under this subtitle shall require the establishment, by regulation, in accordance with the provisions of this section of a national program for reviewing airport noise and access restrictions on operations of Stage 2 and Stage 3 aircraft. Such program shall provide for adequate public notice and comment opportunities on such restrictions.

(2) **LIMITATIONS ON APPLICABILITY.**—

(A) **APPLICABILITY DATE FOR STAGE 2 AIRCRAFT.**—With respect to Stage 2 aircraft, the requirements set forth in subsection (c) shall apply only to restrictions proposed after October 1, 1990.

(B) **APPLICABILITY DATE FOR STAGE 3 AIRCRAFT.**—With respect to Stage 3 aircraft, the requirements set forth in subsections (b) and (d) shall apply only to restrictions that first become effective after October 1, 1990.

(C) **SPECIFIC EXEMPTIONS.**—Subsections (b), (c), and (d) shall not apply to—

(i) a local action to enforce a negotiated or executed airport aircraft noise or access agreement between the airport operator and the aircraft operator in effect on the date of the enactment of this Act;

(ii) a local action to enforce a negotiated or executed airport aircraft noise or access restriction the airport operator and the aircraft operators agreed to before the date of the enactment of this Act;

(iii) an intergovernmental agreement including airport aircraft noise or access restriction in effect on the date of the enactment of this Act;

(iv) a subsequent amendment to an airport aircraft noise or access agreement or restriction in effect on the date of the enactment of this Act that does not reduce or limit aircraft operations or affect aircraft safety;

(v)(I) a restriction which was adopted by an airport operator on or before October 1, 1990, and which was stayed as of October 1, 1990, by a court order or as a result of litigation, if such restriction or a part thereof is subsequently allowed by a court to take effect; and

(II) in any case in which a restriction described in subclause (I) is either partially or totally disallowed by a court, any new restriction imposed by an airport operator to replace such disallowed restriction if such new restriction would not prohibit aircraft operations in effect as of the date of the enactment of this Act; and

(vi) a local action which represents the adoption of the final portion of a program of a staged airport aircraft noise or access restriction where the initial portion of such program was adopted during calendar year 1988 and was in effect on the date of the enactment of this Act.

(D) **ADDITIONAL WORKING GROUP EXEMPTIONS.**—Subsections (b) and (d) shall not apply where the Federal Aviation Administration has prior to the date of the enactment of this Act formed a working group (outside the process established by part 150 of title 14 of the Code of Federal Regulations) with a local airport operator to examine the noise impact of air traffic control procedure changes. In any case in which an agreement relating to noise reductions at such airport is entered into between the airport proprietor and an air carrier or air carrier constituting a majority of the air carrier users of such airport, subsections (b) and (d) shall apply only to local actions to enforce such agreement.

(b) **LIMITATION ON STAGE 3 AIRCRAFT RESTRICTIONS.**—No airport noise or access restriction on the operation of a Stage 3 aircraft, including but not limited to—

(1) a restriction as to noise levels generated on either a single event or cumulative basis;

(2) a limit, direct or indirect, on the total number of Stage 3 aircraft operations;

(3) a noise budget or noise allocation program which would include Stage 3 aircraft;

(4) a restriction imposing limits on hours of operations; and

(5) any other limit on Stage 3 aircraft;

shall be effective unless it has been agreed to by the airport proprietor and all aircraft operators or has been submitted to and ap-

proved by the Secretary pursuant to an airport or aircraft operator's request for approval in accordance with the program established pursuant to this section.

(c) **LIMITATION ON STAGE 2 AIRCRAFT RESTRICTIONS.**—No airport noise or access restriction shall include a restriction on operations of Stage 2 aircraft, unless the airport operator publishes the proposed noise or access restriction and prepares and makes available for public comment at least 180 days before the effective date of the restriction—

(1) an analysis of the anticipated or actual costs and benefits of the existing or proposed noise or access restriction;

(2) a description of alternative restrictions; and

(3) a description of the alternative measures considered which do not involve aircraft restrictions, and a comparison of the costs and benefits of such alternative measures to the costs and benefits of the proposed noise or access restriction.

(d) **APPROVAL OF STAGE 3 AIRCRAFT RESTRICTIONS.**—

(1) **IN GENERAL.**—Not later than the 180th day after the date on which the Secretary receives an airport or aircraft operator's request for approval of a noise or access restriction on the operation of a Stage 3 aircraft, the Secretary shall approve or disapprove such request.

(2) **REQUIRED FINDINGS.**—The Secretary shall not approve a noise or access restriction applying to Stage 3 aircraft operations unless the Secretary finds the following conditions to be supported by substantial evidence:

(A) The proposed restriction is reasonable, nonarbitrary, and nondiscriminatory.

(B) The proposed restriction does not create an undue burden on interstate or foreign commerce.

(C) The proposed restriction is not inconsistent with maintaining the safe and efficient utilization of the navigable airspace.

(D) The proposed restriction does not conflict with any existing Federal statute or regulation.

(E) There has been an adequate opportunity for public comment with respect to the restriction.

(F) The proposed restriction does not create an undue burden on the national aviation system.

(e) **INELIGIBILITY FOR PFC'S AND AIP FUNDS.**—Sponsors of facilities operating under airport aircraft noise or access restrictions on Stage 3 aircraft operations that first became effective after October 1, 1990, shall not be eligible to impose a passenger facility charge under section 1113(e) of the Federal Aviation Act of 1958 and shall not be eligible for grants authorized by section 505 of the Airport and Airway Improvement Act of 1982 after the 90th day following the date on which the Secretary issues a final rule under section 9304(a) of this Act, unless such restrictions have been agreed to by the airport proprietor and aircraft operators or the Secretary has approved the restrictions under this subtitle or the restrictions have been rescinded.

(f) **REEVALUATION.**—The Secretary may reevaluate any noise restrictions previously agreed to or approved under subsection (d) upon the request of any aircraft operator able to demonstrate to the satisfaction of the Secretary that there has been a change in the noise environment of the affected airport and that a review and reevaluation pursuant to the criteria established under subsection

(d) of the previously approved or agreed to noise restriction is therefore justified.

(g) **PROCEDURES FOR REEVALUATION.**—The Secretary shall establish by regulation procedures under which reevaluations under subsection (f) are to be accomplished. A reevaluation under subsection (f) of a restriction shall not occur less than 2 years after a determination under subsection (d) has been made with respect to such restriction.

(h) **EFFECT ON EXISTING LAW.**—Except to the extent required by the application of the provisions of this section, nothing in this subtitle shall be deemed to eliminate, invalidate, or supersede—

(1) existing law with respect to airport noise or access restrictions by local authorities;

(2) any proposed airport noise or access regulation at a general aviation airport where the airport proprietor has formally initiated a regulatory or legislative process on or before October 1, 1990; and

(3) the authority of the Secretary to seek and obtain such legal remedies as the Secretary considers appropriate, including injunctive relief.

49 USC app.
2154.

SEC. 9305. DETERMINATION REGARDING NOISE RESTRICTIONS ON CERTAIN STAGE 2 AIRCRAFT.

The Secretary shall determine by a study the applicability of subsections (a), (b), (c), and (d) of section 9304 to noise restrictions on the operations of Stage 2 aircraft weighing less than 75,000 pounds. In making such determination, the Secretary shall consider—

(1) noise levels produced by such aircraft relative to other aircraft;

(2) the benefits to general aviation and the need for efficiency in the national air transportation system;

(3) the differences in the nature of operations at airports and the areas immediately surrounding such airports;

(4) international standards and accords with respect to aircraft noise; and

(5) such other factors which the Secretary deems necessary.

49 USC app.
2155.

SEC. 9306. FEDERAL LIABILITY FOR NOISE DAMAGES.

In the event that a proposed airport aircraft noise or access restriction is disapproved, the Federal Government shall assume liability for noise damages only to the extent that a taking has occurred as a direct result of such disapproval. Action for the resolution of such a case shall be brought solely in the United States Claims Court.

49 USC app.
2156.

SEC. 9307. LIMITATION ON AIRPORT IMPROVEMENT PROGRAM REVENUE.

Under no conditions shall any airport receive revenues under the provisions of the Airport and Airway Improvement Act of 1982 or impose or collect a passenger facility charge under section 1113(e) of the Federal Aviation Act of 1958 unless the Secretary assures that the airport is not imposing any noise or access restriction not in compliance with this subtitle.

49 USC app.
2157.

SEC. 9308. PROHIBITION ON OPERATION OF CERTAIN AIRCRAFT NOT COMPLYING WITH STAGE 3 NOISE LEVELS.

(a) **GENERAL RULE.**—After December 31, 1999, no person may operate to or from an airport in the United States any civil subsonic

turbojet aircraft with a maximum weight of more than 75,000 pounds unless such aircraft complies with the Stage 3 noise levels, as determined by the Secretary.

(b) **WAIVER.**—

(1) **APPLICATION.**—If, by July 1, 1999, at least 85 percent of the aircraft used by an air carrier to provide air transportation comply with the Stage 3 noise levels, such carrier may apply for a waiver of the prohibition set forth in subsection (a) for the remaining 15 or less percent of the aircraft used by the carrier to provide air transportation. Such application must be filed with the Secretary no later than January 1, 1999, and must include a plan with firm orders for making all aircraft used by the air carrier to provide air transportation to comply with such noise levels not later than December 31, 2003.

(2) **GRANTING OF WAIVER.**—The Secretary may grant a waiver under this subsection if the Secretary finds that granting such waiver is in the public interest. In making such a finding, the Secretary shall consider the effect of granting such waiver on competition in air carrier industry and on small community air service.

(3) **LIMITATION.**—A waiver granted under this subsection may not permit the operation of Stage 2 aircraft in the United States after December 31, 2003.

(c) **COMPLIANCE SCHEDULE.**—The Secretary shall, by regulation, establish a schedule for phased-in compliance with the prohibition set forth in subsection (a). The period of such phase-in shall begin on the date of the enactment of this Act and end before December 31, 1999. Such regulations shall establish interim compliance dates. Such schedule for phased-in compliance shall be based upon a detailed economic analysis of the impact of the phaseout date for Stage 2 aircraft on competition in the airline industry, including the ability of air carriers to achieve capacity growth consistent with the projected rates of growth for the airline industry, the impact of competition within the airline and air cargo industries, the impact on nonhub and small community air service, and the impact on new entry into the airline industry, and on an analysis of the impact of aircraft noise on persons residing near airports.

(d) **EXEMPTION FOR NONCONTIGUOUS AIR SERVICE.**—This section and section 9309 shall not apply to aircraft which are used solely to provide air transportation outside the 48 contiguous States. Any civil subsonic turbojet aircraft with a maximum weight of more than 75,000 pounds which is imported into a noncontiguous State or a territory or possession of the United States on or after the date of the enactment of this Act may not be used to provide air transportation in the 48 contiguous States unless such aircraft complies with the Stage 3 noise levels.

(e) **VIOLATIONS.**—Violations of this section and section 9309 and regulations issued to carry out such sections shall be subject to the same civil penalties and procedures as are provided by title IX of the Federal Aviation Act of 1958 for violations of title VI.

(f) **JUDICIAL REVIEW.**—Actions taken by the Secretary under this section and section 9309 shall be subject to judicial review in accordance with section 1006 of the Federal Aviation Act of 1958.

(g) **REPORTS.**—Beginning with calendar year 1992, each air carrier shall submit to the Secretary an annual report on the progress such carrier is making toward complying with the requirements of this section (including the regulations issued to carry out this section),

and the Secretary shall transmit to Congress an annual report on the progress being made toward such compliance.

(h) **DEFINITIONS.**—As used in this section, the following definitions apply:

(1) **AIR CARRIER; AIR TRANSPORTATION; UNITED STATES.**—The terms “air carrier”, “air transportation”, and “United States” have the meanings such terms have under section 101 of the Federal Aviation Act of 1958.

(2) **STAGE 3 NOISE LEVELS.**—The term “Stage 3 noise levels” means the Stage 3 noise levels set forth in part 36 of title 14, Code of Federal Regulations, as in effect on the date of the enactment of this Act.

49 USC app.
2158.

SEC. 9309. NONADDITION RULE.

(a) **GENERAL RULE.**—Except as provided in subsection (b) of this section, no person may operate a civil subsonic turbojet aircraft with a maximum weight of more than 75,000 pounds which is imported into the United States on or after the date of the enactment of this Act unless—

(1) it complies with the Stage 3 noise levels, or

(2) it was purchased by the person who imports the aircraft into the United States under a written contract executed before such date of enactment.

(b) **EXEMPTION FOR COMPLYING MODIFICATIONS.**—The Secretary may provide an exemption from the requirements of subsection (a) to permit a person to obtain modifications to an aircraft to meet the Stage 3 noise levels.

(c) **LIMITATION ON STATUTORY CONSTRUCTION.**—For the purposes of this section, an aircraft shall not be considered to have been imported into the United States if such aircraft—

(1) on the date of the enactment of this Act, is owned—

(A) by a corporation, trust, or partnership which is organized under the laws of the United States or any State (including the District of Columbia);

(B) by an individual who is a citizen of the United States;
or

(C) by any entity which is owned or controlled by a corporation, trust, partnership, or individual described in this paragraph; and

(2) enters into the United States not later than 6 months after the date of the expiration of a lease agreement (including any extensions thereof) between an owner described in paragraph (1) and a foreign air carrier.

TITLE X—MISCELLANEOUS USER FEES AND OTHER PROVISIONS

Subtitle A—Customs User Fees and Other Trade Provisions

PART I—CUSTOMS USER FEES

SEC. 10001. CUSTOMS USER FEES.

(a) **EXTENSION OF EFFECTIVE PERIOD FOR FEES.**—Paragraph (3) of section 13031(j) of the Consolidated Omnibus Budget Reconciliation Act of 1985 (19 U.S.C. 58c(j)(3)) is amended by striking out “1991” and inserting “1995”.

(b) **ADJUSTMENT OF FEES FOR FORMALLY-ENTERED MERCHANDISE.**—Paragraph (9) of section 13031(a) of the Consolidated Omnibus Budget Reconciliation Act of 1985 (19 U.S.C. 58c(a)(9)) is amended to read as follows:

“(9)(A) For the processing of merchandise that is formally entered or released during any fiscal year, a fee in an amount equal to 0.17 percent ad valorem, unless adjusted under subparagraph (B).

“(B)(i) The Secretary of the Treasury may adjust the ad valorem rate specified in subparagraph (A) to an ad valorem rate (but not to a rate of more than 0.19 percent nor less than 0.15 percent) that would, if charged, offset the salaries and expenses that will likely be incurred by the Customs Service in the processing of such entries and releases during the fiscal year in which such costs are incurred.

“(ii) In determining the amount of any adjustment under clause (i), the Secretary of the Treasury shall take into account whether there is a surplus or deficit in the fund established under section 613A of the Tariff Act of 1930 with respect to the provision of customs services for the processing of formal entries and releases of merchandise.

“(iii) An adjustment may not be made under clause (i) with respect to the fee charged during any fiscal year unless the Secretary of the Treasury—

“(I) not later than 45 days after the date of the enactment of the Act providing full-year appropriations for the Customs Service for that fiscal year, publishes in the Federal Register a notice of intent to adjust the fee under this paragraph and the amount of such adjustment;

“(II) provides a period of not less than 30 days following publication of the notice described in subclause (I) for public comment and consultation with the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives regarding the proposed adjustment and the methodology used to determine such adjustment;

“(III) upon the expiration of the period provided under subclause (II), notifies such committees in writing regarding the final determination to adjust the fee, the amount of such adjustment, and the methodology used to determine such adjustment; and

“(IV) upon the expiration of the 15-day period following the written notification described in subclause (III), submits for publication in the Federal Register notice of the final determination regarding the adjustment of the fee.

“(iv) The 15-day period referred to in clause (iii)(IV) shall be computed by excluding—

“(I) the days on which either House is not in session because of an adjournment of more than 3 days to a day certain or an adjournment of the Congress sine die; and

“(II) any Saturday and Sunday, not excluded under subclause (I), when either House is not in session.

“(v) An adjustment made under this subparagraph shall become effective with respect to formal entries and releases made on or after the 15th calendar day after the date of publication of the notice described in clause (iii)(IV) and shall remain in effect until adjusted under this subparagraph.

“(C) If for any fiscal year, the Secretary of the Treasury determines not to make an adjustment under subparagraph (B), the Secretary shall, within the time prescribed under subparagraph (B)(iii)(I), submit a written report to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives detailing the reasons for maintaining the current fee and the methodology used for computing such fee.

“(D) Any fee charged under this paragraph, whether or not adjusted under subparagraph (B), is subject to the limitations in subsection (b)(8)(A).”.

(c) **AGGREGATION OF MERCHANDISE PROCESSING FEES.**—Section 111(f)(1)(B) of the Customs and Trade Act of 1990 (Public Law 101-382) is amended by striking out “determined in” and inserting “currently in effect under”.

(d) **CUSTOMS SERVICE ADMINISTRATION.**—Section 113 of the Customs and Trade Act of 1990 is amended—

(1) by inserting “and” after the semicolon at the end of subsection (a)(1);

(2) by striking out the semicolon at the end of subsection (a)(2) and inserting a period;

(3) by striking out paragraphs (3), (4), and (5) of subsection (a); and

(4) by striking out “Committees referred to in subsection (a)(5)” in subsection (b) and inserting “Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate”.

(e) **MERCHANDISE PROCESSING FEES FOR CERTAIN SMALL AIRPORTS.**—

(1) Section 13031(a)(10)(C) of the Consolidated Omnibus Budget Reconciliation Act of 1985 (19 U.S.C. 58c(a)(10)(C)) is amended by striking “applies,” and inserting “applies, if more than 25,000 informal entries were cleared through such airport or facility during the fiscal year preceding such entry or release,”.

(2) Section 13031(b)(9) of the Consolidated Omnibus Budget Reconciliation Act of 1985 (19 U.S.C. 58c(b)(9)) is amended by inserting “, if more than 25,000 informal entries were cleared through such airport or facility during the preceding fiscal year” in subparagraph (B)(ii) before the end period.

19 USC 58c note.

19 USC 2082.

(f) **MANUAL ENTRIES AND RELEASES.**—Clause (ii) of section 13031(b)(8)(C) of the Consolidated Omnibus Budget Reconciliation Act of 1985 (19 U.S.C. 58c(b)(8)(C)(ii)) is amended to read as follows:

“(ii) any reference to a manual formal or informal entry or release includes any entry or release filed by a broker or importer that requires the inputting of cargo selectivity data into the Automated Commercial System by customs personnel, except when—

“(I) the broker or importer is certified as an ABI cargo release filer under the Automated Commercial System at any port within the United States, or

“(II) the entry or release is filed at ports prior to the full implementation of the cargo selectivity data system by the Customs Service at such ports.”.

(g) **EFFECTIVE DATES.**—

19 USC 58c note.

(1) **IN GENERAL.**—The amendments made by subsections (b), (c), and (d) shall take effect on the date of the enactment of the Act providing full-year appropriations for the Customs Service for fiscal year 1992, and shall apply to fiscal years beginning on and after October 1, 1991.

(2) **MERCHANDISE PROCESSING FEES FOR SMALL AIRPORTS.**—The amendments made by subsection (e) shall take effect as if included in section 111 of the Customs and Trade Act of 1990.

(3) **MANUAL ENTRIES AND RELEASES.**—The amendment made by subsection (f) shall take effect on the date of the enactment of this Act.

PART II—TECHNICAL CORRECTIONS

SEC. 10011. TECHNICAL AMENDMENTS TO THE HARMONIZED TARIFF SCHEDULE.

(a) **REDESIGNATIONS.**—

(1) **IN GENERAL.**—Each subheading of the Harmonized Tariff Schedule of the United States that is listed in column A is redesignated as the subheading listed in column B opposite such column A subheading:

Column A	Column B
5111.20.60	5111.20.90
5111.30.60	5111.30.90
5111.90.70	5111.90.90
5112.19.10	5112.19.20
5112.19.60	5112.19.90
5112.90.60	5112.90.90
6116.10.10	6116.10.08
6116.10.15	6116.10.18
6116.10.25	6116.10.45
6116.10.35	6116.10.70
6116.10.60	6116.10.90
6116.92.10	6116.92.08
6116.92.20	6116.92.60
6116.92.30	6116.92.90
6116.93.10	6116.93.08
6116.93.15	6116.93.60
6116.93.20	6116.93.90
6116.99.30	6116.99.35
6116.99.60	6116.99.50
6116.99.90	6116.99.80
6216.00.10	6216.00.08
6216.00.15	6216.00.12
6216.00.20	6216.00.18

6216.00.27	6216.00.28
6216.00.31	6216.00.32
6216.00.34	6216.00.35
6216.00.38	6216.00.39
6216.00.44	6216.00.46
6216.00.49	6216.00.52
6216.00.50	6216.00.80
6216.00.60	6216.00.90
6702.90.40	6702.90.35
6702.90.60	6702.90.65
8712.00.10	8712.00.15
8712.00.20	8712.00.25
8712.00.30	8712.00.35
8714.94.20	8714.94.15
8714.94.50	8714.94.60
9022.90.80	9022.90.90
9603.10.20	9603.10.25
9603.10.70	9603.10.90

(2) **STAGED RATE REDUCTION.**—Any staged reductions of a special rate of duty set forth in a subheading of the Harmonized Tariff Schedule of the United States listed in column A in paragraph (1) that were proclaimed by the President before October 1, 1990, and are scheduled to take effect on or after October 1, 1990, shall also apply to the corresponding special rates of duty set forth in the corresponding subheading listed in column B opposite such column A subheading.

(b) **MISCELLANEOUS AMENDMENTS.**—The Harmonized Tariff Schedule of the United States is further amended as follows:

(1) Chapter 61 is amended by striking out subheading 6116.10.50.

(2) Chapter 62 is amended by striking out subheadings 6216.00.23, 6216.00.29, and 6216.00.47.

(3) Subheading 6116.10.90, as redesignated by subsection (a), is amended—

(A) by striking out the superior heading for such subheading, and

(B) by striking out the article description and inserting “With fourchettes”, with the new article description having the same degree of indentation as the superior heading for subheading 6116.10.70, as redesignated by subsection (a).

(4) Subheading 6216.00.28, as redesignated by subsection (a), is amended—

(A) by striking out the superior heading for such subheading, and

(B) by inserting the article description for such subheading at the same degree of indentation as the superior heading for subheading 6216.00.18, as redesignated by subsection (a).

(5) Subheading 6216.00.32, as redesignated by subsection (a), is amended—

(A) by striking out the superior heading for such subheading, and

(B) by striking out the article description and inserting “With fourchettes”, with the new article description having the same degree of indentation as the article description for subheading 6216.00.35, as redesignated by subsection (a).

(6) Subheading 6216.00.52, as redesignated by subsection (a), is amended by inserting the article description for such subheading at the same degree of indentation as subheading 6216.00.46, as redesignated by subsection (a).

(7) The article descriptions for subheadings 6116.10.08, 6116.92.08, 6116.93.08, 6116.99.35, 6216.00.08, 6216.00.35, and 6216.00.46, as redesignated by subsection (a), are each amended to read as follows: "Other gloves, mittens, and mitts, all the foregoing specially designed for use in sports, including ski and snowmobile gloves, mittens, and mitts".

(8) The superior heading for subheadings 8712.00.25 and 8712.00.35, as redesignated by subsection (a), is amended by striking out "65" and inserting "63.5".

(9) Heading 9902.30.07 is amended by striking out "2929.90.10" and inserting "2929.10.40".

(10) Heading 9902.30.08 is amended by striking out "2907.29.30" and inserting "2907.19.50".

(11) Heading 9902.30.42 is amended by striking out "19532-03-07" and inserting "19532-03-7".

(12) The article description for heading 9902.30.56 is amended by striking out "hydroxethyl" and inserting "hydroxyethyl".

(13) Heading 9902.30.83 (as enacted by section 388 of the Customs and Trade Act of 1990) is redesignated as heading 9902.31.11 and, as so redesignated, is amended by striking out "piperadiny" and inserting "piperidiny".

(14) Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.70.20	Fiberglass tire cord fabric woven from electrically nonconductive continuous fiberglass filaments 9 microns in diameter or 10 microns in diameter and impregnated with resorcinol formaldehyde latex treatment for adhesion to polymeric compounds (provided for in subheading 7019.20.10, 7019.20.20, or 7019.20.50).....	Free	No change	No change	On or before 12/31/92	”.
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(15) Heading 9902.84.83 is amended by striking out "(A,C,E,IL)" and inserting "(A,C,CA,E,IL)".

(16) Heading 9902.87.14 is amended by striking out "brakes," the first place it appears.

(17) The article description for heading 9902.94.01 is amended by striking out "Furniture seats" and inserting "Furniture, seats,".

(c) EFFECTIVE DATE.—

(1) Subject to paragraphs (2) and (3), the amendments made by subsections (a) and (b) apply with respect to articles entered, or

withdrawn from warehouse for consumption, on or after October 1, 1990.

(2) Any amendment made by subsection (a) or (b) to a provision of the Harmonized Tariff Schedule of the United States that was the subject of an amendment made by title III of the Customs and Trade Act of 1990 shall—

(A) be treated as applying to that provision as established or amended by such title III; and

(B) if the amendment made by such title III has retroactive application under section 485(b) of such Act, be treated as applying with respect to entries made after the relevant applicable date (as defined in paragraph (2)(A) of such section 485(b)).

(3) Notwithstanding section 514 of the Tariff Act of 1930 or any other provision of law, upon proper request filed with the appropriate customs officer before April 1, 1991, any entry—

(A) which was made after December 31, 1988, and before October 1, 1990; and

(B) with respect to which there would have been a lesser duty if any amendment made by subsection (b) (1) through (7) applied to such entry;

shall be liquidated or reliquidated as though such amendment applied to such entry.

SEC. 10012. TECHNICAL AMENDMENTS TO CERTAIN CUSTOMS LAWS.

(a) CUSTOMS FORFEITURE FUND.—

19 USC 1613b.

(1) Paragraph (5) of section 121 of the Customs and Trade Act of 1990 is repealed and subsection (f) of section 613A of the Tariff Act of 1930 shall be applied as if the amendment made by such paragraph (5) had not been enacted.

19 USC 1613b.

(2) Paragraph (2) of such section 613A(f) of the Tariff Act of 1930 (as in effect after the application of paragraph (1)) is amended to read as follows:

“(2)(A) Subject to subparagraph (B), there are authorized to be appropriated from the Fund not to exceed \$20,000,000 for each fiscal year to carry out the purposes set forth in subsections (a)(3) and (b) for such fiscal year.

“(B) Of the amount authorized to be appropriated under subparagraph (A), not to exceed the following, shall be available to carry out the purposes set forth in subsection (a)(3):

“(i) \$14,855,000 for fiscal year 1991.

“(ii) \$15,598,000 for fiscal year 1992.”.

19 USC 1613b
note.

(b) CERTAIN ENTRIES.—Section 484 of the Customs and Trade Act of 1990 (Public Law 101-382) is amended by striking out “1801-000027” and inserting “1801-7-000027”.

(c) EFFECTIVE DATE.—The provisions of this section take effect August 21, 1990.

SEC. 10013. STAGED RATE REDUCTION FOR ETBE.

(a) IN GENERAL.—Section 484G(b) of the Customs and Trade Act of 1990 is amended to read as follows:

“(b) STAGED RATE REDUCTION.—The President may proclaim such modifications to the rates of duty set forth in subheading 9901.00.52 with respect to goods originating in the territory of Canada as will result in reduction of such rates in equal annual stages and will make such products free of duty effective January 1, 1998.”.

(b) **EFFECTIVE DATE.**—The amendment made by this section shall take effect as if included in section 484G of the Customs and Trade Act of 1990.

Subtitle B—Patent and Trademark Office User Fees

SEC. 10101. PATENT AND TRADEMARK OFFICE USER FEES.

(a) **SURCHARGES.**—There shall be a surcharge, during fiscal years 1991 through 1995, of 69 percent, rounded by standard arithmetic rules, on all fees authorized by subsections (a) and (b) of section 41 of title 35, United States Code. 35 USC 41 note.

(b) **USE OF SURCHARGES.**—Notwithstanding section 3302 of title 31, United States Code, beginning in fiscal year 1991, all surcharges collected by the Patent and Trademark Office— 35 USC 41 note.

(1) in fiscal year 1991—

(A) shall be credited to a separate account established in the Treasury and ascribed to the Patent and Trademark Office activities in the Department of Commerce as offsetting receipts, and

(B) \$91,000,000 shall be available only to the Patent and Trademark Office, to the extent provided in appropriation Acts, and the additional surcharge receipts, totalling \$18,807,000, shall be available only to the Patent and Trademark Office without appropriation, for all authorized activities and operations of the office, including all direct and indirect costs of services provided by the office,

(2) in fiscal years 1992 through 1995—

(A) shall be credited to a separate account established in the Treasury and ascribed to the Patent and Trademark Office activities in the Department of Commerce as offsetting receipts, and

(B) shall be available only to the Patent and Trademark Office, to the extent provided in appropriation Acts, for all authorized activities and operations of the office, including all direct and indirect costs of services provided by the office, and

(3) shall remain available until expended.

(c) **REVISIONS.**—In fiscal years 1991 through 1995, surcharges established under subsection (a) may be revised periodically by the Commissioner of Patents and Trademarks, subject to the provisions of section 553 of title 5, United States Code, in order to ensure that the following amounts, but not more than the following amounts, of patent and trademark user fees are collected: 35 USC 41 note.

(1) \$109,807,000 in fiscal year 1991.

(2) \$95,000,000 in fiscal year 1992.

(3) \$99,000,000 in fiscal year 1993.

(4) \$103,000,000 in fiscal year 1994.

(5) \$107,000,000 in fiscal year 1995.

(d) **REPEAL.**—Section 105(a) of Public Law 100-703 (102 Stat. 4675) is repealed.

(e) **REPORT ON FEES.**—The Commissioner of Patents and Trademarks shall study the structure of all fees collected by the Patent and Trademark Office and, not later than May 1, 1991, shall submit to the Congress a report on all fees to be collected by the office in

fiscal years 1992 through 1995. The report shall include a proposed schedule of fees that would distribute the surcharges provided by subsection (a) among all fees collected by the office, and recommendations for any statutory changes that may be necessary to implement the proposals contained in the report.

35 USC 1 note.

SEC. 10102. FEDERAL AGENCY STATUS.

For the purposes of Federal law, the Patent and Trademark Office shall be considered a Federal agency. In particular, the Patent and Trademark Office shall be subject to all Federal laws pertaining to the procurement of goods and services that would apply to a Federal agency using appropriated funds, including the Federal Property and Administrative Services Act of 1949 and the Office of Federal Procurement Policy Act.

35 USC 41 note.

SEC. 10103. EFFECT ON OTHER LAW.

Except for section 10101(d), nothing in this subtitle affects the provisions of Public Law 100-703 (102 Stat. 4674 and following).

Subtitle C—Science and Technology User Fees

SEC. 10201. NATIONAL OCEANIC AND ATMOSPHERIC ADMINISTRATION USER FEES.

(a) **AMENDMENTS.**—Section 409 of the Act of November 17, 1988 (15 U.S.C. 1534) is amended—

(1) in subsection (a), by striking “archived” and all that follows and inserting in lieu thereof “and information and products derived therefrom collected and/or archived by the National Oceanic and Atmospheric Administration.”;

(2) in subsection (b)(1)—

(A) by inserting “, information, and products” immediately after “data” the first place it appears; and

(B) by striking “data is” and inserting in lieu thereof “data, information, and products are”;

(3) in subsection (b)(2)—

(A) by inserting “, information, or products” immediately after “data” the first place it appears; and

(B) by striking “data exchange basis” and inserting in lieu thereof “basis of exchanging such data, information, and products”;

(4) in subsection (b), by inserting at the end the following new paragraph:

“(3) The Secretary shall waive the assessment of fees authorized by subsection (a) as necessary to continue to provide weather warnings, watches, and similar products and services essential to the mission of the National Oceanic Atmospheric Administration.”;

(5) by amending paragraph (1) of subsection (d) to read as follows:

“(1) The initial schedule of fees established by the National Environmental Satellite, Data, and Information Service for archived data shall remain in effect for the 3-year period beginning on the date that the fees under that schedule take effect.”;

(6) in subsections (d), (e), and (f)(1), by inserting “by the National Environmental Satellite, Data, and Information Service for archived data” immediately after “under this section” each place it appears; and

(7) in subsection (g), by striking the period at the end and inserting in lieu thereof the following: “, including the authority of the Secretary pursuant to section 1307 of title 44, United States Code. Nothing in this section shall be construed to authorize the Secretary to assess fees for nautical and aeronautical products of the National Oceanic and Atmospheric Administration in addition to those fees authorized under section 1307 of title 44, United States Code.”.

(b) **EFFECT OF AMENDMENTS.**—(1) The increase in revenues to the United States attributable to the amendments made by subsection (a) shall not exceed—

15 USC 1534
note.

(A) \$2,000,000 for each of the fiscal years 1991, 1992, and 1993; and

(B) \$3,000,000 for each of the fiscal years 1994 and 1995.

(2) Increases in revenues to the United States described in paragraph (1) shall be achieved by the Secretary of Commerce through fair and equitable increases in fees for services offered by the various programs of the National Oceanic and Atmospheric Administration.

(3) The Secretary of Commerce shall notify the Congress of any changes in fee schedules under section 409 of the Act of November 17, 1988 (15 U.S.C. 1534), before such changes take effect.

SEC. 10202. RADON MEASUREMENT PROFICIENCY.

Section 305(e) of the Toxic Substances Control Act is amended by adding at the end the following new paragraphs: 15 USC 2665.

“(5) **RESEARCH.**—The Administrator shall, in conjunction with other Federal agencies, conduct research to develop, test, and evaluate radon and radon progeny measurement methods and protocols. The purpose of such research shall be to assess the ability of those methods and protocols to accurately assess exposure to radon progeny. Such research shall include—

“(A) conducting comparisons among radon and radon progeny measurement techniques;

“(B) developing measurement protocols for different building types under varying operating conditions; and

“(C) comparing the exposures estimated by stationary monitors and protocols to those measured by personal monitors, and issue guidance documents that—

“(i) provide information on the results of research conducted under this paragraph; and

“(ii) describe model State radon measurement and mitigation programs.

“(6) **MANDATORY PROFICIENCY TESTING PROGRAM STUDY.**—(A) The Administrator shall conduct a study to determine the feasibility of establishing a mandatory proficiency testing program that would require that—

“(i) any product offered for sale, or device used in connection with a service offered to the public, for the measurement of radon meets minimum performance criteria; and

“(ii) any operator of a device, or person employing a technique, used in connection with a service offered to the public for the measurement of radon meets a minimum level of proficiency.

“(B) The study shall also address procedures for—

“(i) ordering the recall of any product sold for the measurement of radon which does not meet minimum performance criteria;

“(ii) ordering the discontinuance of any service offered to the public for the measurement of radon which does not meet minimum performance criteria; and

“(iii) establishing adequate quality assurance requirements for each company offering radon measurement services to the public to follow.

The study shall identify enforcement mechanisms necessary to the success of the program. The Administrator shall report the findings of the study with recommendations to Congress by March 1, 1991.

“(7) USER FEE.—In addition to any charge imposed pursuant to paragraph (2), the Administrator shall collect user fees from persons seeking certification under the radon proficiency program in an amount equal to \$1,500,000 to cover the Environmental Protection Agency’s cost of conducting research pursuant to paragraph (5) for each of the fiscal years 1991, 1992, 1993, 1994, and 1995. Such funds shall be deposited in the account established pursuant to paragraph (3).”.

SEC. 10203. DEPARTMENT OF ENERGY USER FEE STUDY.

The Secretary of Energy shall undertake a study of the Department of Energy’s user fee assessment and collection practices, and shall make recommendations on ways to—

- (1) reasonably increase revenues to the United States through user fees, consistent with the mission of the Department; and
- (2) improve user fee collection practices.

The Secretary of Energy shall submit a report containing such findings and recommendations to the Congress within 6 months after the date of enactment of this Act. There are authorized to be appropriated to the Secretary of Energy for carrying out this section not to exceed \$500,000 for fiscal year 1991, from funds otherwise available to the Department of Energy.

SEC. 10204. DEPARTMENT OF TRANSPORTATION COMMERCIAL SPACE LAUNCH STUDY.

(a) The Secretary of Transportation shall report on actions by the Department of Transportation for the assessment and collection of licensing fees under the Commercial Space Launch Act (49 U.S.C. App. 2601 et seq.).

(b) The Secretary shall submit a report containing such findings to the Congress within 6 months after the date of enactment of this Act.

SEC. 10205. NATIONAL INSTITUTE OF STANDARDS AND TECHNOLOGY COST RECOVERY STUDY.

(a) The Secretary of Commerce shall undertake a study of current practices at, and any suggested improvements consistent with the mission of, the National Institute of Standards and Technology for recovering the costs of services and materials provided to private and nonprofit organizations, including services provided on a proprietary basis to users of Institute facilities.

(b) The Secretary shall submit a report containing such findings to the Congress within 6 months after the date of enactment of this Act.

Subtitle D—Travel and Tourism Facilitation Fee

SEC. 10301. UNITED STATES TRAVEL AND TOURISM FACILITATION FEE.

(a) UNITED STATES TRAVEL AND TOURISM ADMINISTRATION FACILITATION FEE.—The International Travel Act of 1961 (22 U.S.C. 2121 et seq.) is amended by adding at the end the following:

“SEC. 306. (a) To the extent not inconsistent with treaties or international agreements entered into by the United States, the Secretary, on a calendar quarterly basis beginning January 1, 1991, shall charge and collect from each commercial airline and passenger cruise ship line transporting passengers to the United States, a United States Travel and Tourism Administration Facilitation Fee, in an amount determined under subsection (b). 22 USC 2128.

“(b)(1) During the period from January 1, 1991, through December 31, 1991, the Secretary shall charge each commercial airline and passenger cruise ship line an amount equal to one dollar multiplied by the number of aliens described in section 101(a)(15)(B) of the Immigration and Nationality Act (8 U.S.C. 1101(a)(15)(B)) arriving at any port within the United States aboard a commercial aircraft or cruise ship of such airline or passenger cruise ship line during that calendar quarter.

“(2) Commencing in 1991, the Secretary shall each year determine and publish the amount of the fee described in subsection (a) for the 12-month period commencing on January 1 of the succeeding calendar year, as follows:

“(A) The Secretary (in consultation with the Attorney General and the Secretary of State) shall estimate the number of aliens described in section 101(a)(15)(B) of the Immigration and Nationality Act (8 U.S.C. 1101(a)(15)(B)) expected to enter the United States during such succeeding calendar year, based upon the number of such aliens who entered the United States during the previous calendar year (as reported or estimated by the Attorney General) and such other available information as the Secretary deems reliable.

“(B) The Secretary shall divide the amount appropriated to the United States Travel and Tourism Administration for the fiscal year during which such determination is made by the number of aliens described in subparagraph (A) expected by the Secretary to enter the United States during the calendar year described in such subparagraph, as estimated by the Secretary under such subparagraph, and shall round the result up to the nearest quarter-dollar.

“(C) The Secretary shall publish in the Federal Register the estimate required by subparagraph (A), together with a description of the information supporting such estimate, and the amount of the fee determined under subparagraph (B) which shall be applicable during the 12-month period commencing on January 1 of the succeeding calendar year.

“(D) For each calendar quarter beginning after December 31, 1991, the Secretary shall charge each commercial airline and passenger cruise ship line an amount equal to the fee amount determined under subparagraph (B) and applicable under subparagraph (C) multiplied by the number of aliens described in section 101(a)(15)(B) of the Immigration and Nationality Act

(8 U.S.C. 1101(a)(15)(B)) arriving at any port within the United States aboard a commercial aircraft or cruise ship of such airline or passenger cruise ship line during that calendar quarter.

“(3) Neither the estimate of the Secretary under paragraph (2)(A) nor the amount determined by the Secretary under paragraph (2)(B) shall be subject to judicial review.

“(c) Each commercial airline and passenger cruise ship line shall remit the fee charged by the Secretary under subsection (b), in United States dollars, no later than 31 days after the close of the calendar quarter of the arrival of the aliens on which the calculation of the fee is based.

“(d) The Secretary shall deposit the fees received pursuant to subsection (c) in the general fund of the Treasury as offsetting receipts and ascribed to the travel and tourism activities of the Secretary.

“(e) Beginning on October 1, 1992, the aggregate amounts collected for the fee charged under this section shall at least equal the appropriations made for the travel and tourism activities of the Secretary under this Act, but at no time shall the aggregate of amounts collected for any fiscal year under this section exceed 105 percent of the aggregate of appropriations made for such fiscal year for activities to be funded by such fees.

“(f) The Secretary may prescribe such rules and regulations as may be necessary to carry out the provisions of this section.”.

(b) **CIVIL PENALTIES AND ENFORCEMENT.**—The International Travel Act of 1961, as amended by subsection (a), is amended by adding at the end the following:

“SEC. 307. (a) Any commercial airline or commercial cruise ship line which is found by the Secretary or the Secretary’s designee, after notice and an opportunity for a hearing, to have failed to pay to the Secretary, by the due date, the fee charged by the Secretary under section 306(a), may be ordered by the Secretary or the Secretary’s designee to pay any fee amount outstanding plus interest on any late payment and, in addition, to pay a civil penalty not to exceed \$5,000 for each day payment to the Secretary is not made or was made late. The amount of such civil penalty shall be assessed by the Secretary or the Secretary’s designee by written notice. In determining the amount of such penalty, the Secretary or the Secretary’s designee shall take into account the nature, circumstances, extent, and gravity of the violation, and, with respect to the violator, the degree of culpability, and history of prior offenses, ability to pay, and such other matters as justice may require. Each day a payment to the Secretary required by this Act is late shall constitute a separate violation of this Act.

“(b) If any commercial airline or cruise ship line fails to pay as ordered by the Secretary or the Secretary’s designee, the Attorney General may, upon request of the Secretary, bring a civil action in any appropriate United States district court for the recovery of the amount ordered to be paid.

“(c) Before requesting the Attorney General to bring a civil action, the Secretary may compromise, modify, or remit, with or without conditions, any civil penalty which is subject to imposition or which has been imposed under subsection (a).

“(d) For the purpose of conducting any hearing under subsection (a), the Secretary or the Secretary’s designee may issue subpoenas for the attendance and testimony of witnesses and the production of

relevant papers, books, and documents, and may administer oaths. Witnesses summoned shall be paid the same fees and mileage that are paid to witnesses in the courts of the United States. In case of contempt or refusal to obey a subpoena served upon any person pursuant to this subsection, the United States district court for any district in which such person is found, resides, or transacts business, upon application by the United States and after notice to such person, shall have jurisdiction to issue an order requiring such person to appear and give testimony before the Secretary or the Secretary's designee or to appear and produce papers, books, and documents before the Secretary or the Secretary's designee, or both, and any failure to obey such order of the court may be punished by such court as a contempt thereof."

Subtitle E—Coast Guard User Fees

SEC. 19401. ESTABLISHMENT AND COLLECTION OF FEES FOR COAST GUARD SERVICES.

(a) IN GENERAL.—Section 2110 of title 46, United States Code, is amended to read as follows:

"§ 2110. Fees

"(a)(1) Except as otherwise provided in this title, the Secretary shall establish a fee or charge for a service or thing of value provided by the Secretary under this subtitle, in accordance with section 9701 of title 31.

"(2) The Secretary may not establish a fee or charge under paragraph (1) for inspection or examination of a non-self-propelled tank vessel under part B of this title that is more than \$500 annually.

"(3) The Secretary may, by regulation, adjust a fee or charge collected under this subsection to accommodate changes in the cost of providing a specific service or thing of value, but the adjusted fee or charge may not exceed the total cost of providing the service or thing of value for which the fee or charge is collected, including the cost of collecting the fee or charge.

"(4) The Secretary may not collect a fee or charge under this subsection that is in conflict with the international obligations of the United States.

"(5) The Secretary may not collect a fee or charge under this subsection for any search or rescue service.

"(b)(1) The Secretary shall establish a fee or charge as provided in paragraph (2) of this subsection, and collect it annually in fiscal years 1991, 1992, 1993, 1994, and 1995, from the owner or operator of each recreational vessel that is greater than 16 feet in length.

"(2) The fee or charge established under paragraph (1) of this subsection is as follows:

"(A) for vessels greater than 16 feet in length but less than 20 feet, not more than \$25;

"(B) for vessels of at least 20 feet in length but less than 27 feet, not more than \$35;

"(C) for vessels of at least 27 feet in length but less than 40 feet, not more than \$50; and

"(D) for vessels of at least 40 feet in length, not more than \$100.

“(3) The fee or charge established under this subsection applies only to vessels operated on the navigable waters of the United States where the Coast Guard has a presence.

“(4) The fee or charge established under this subsection does not apply to a—

“(A) public vessel; or

“(B) vessel deemed to be a public vessel under section 827 of title 14.

“(c) In addition to the collection of fees and charges established under subsections (a) and (b), the Secretary may recover appropriate collection and enforcement costs associated with delinquent payments of the fees and charges.

“(d)(1) The Secretary may employ any Federal, State, or local agency or instrumentality, or any private enterprise or business, to collect a fee or charge established under this section. A private enterprise or business selected by the Secretary to collect fees or charges—

“(A) shall be subject to reasonable terms and conditions agreed to by the Secretary and the enterprise or business;

“(B) shall provide appropriate accounting to the Secretary; and

“(C) may not institute litigation as part of that collection.

“(2) A Federal agency shall account for the agency’s costs of collecting the fee or charge under this subsection as a reimbursable expense, and the costs shall be credited to the account from which expended.

“(e) A person that violates this section by failing to pay a fee or charge established under this section is liable to the United States Government for a civil penalty of not more than \$5,000 for each violation.

“(f) When requested by the Secretary, the Secretary of the Treasury shall deny the clearance required by section 4197 of the Revised Statutes of the United States (46 App. U.S.C. 91) to a vessel for which a fee or charge established under this section has not been paid until the fee or charge is paid or until a bond is posted for the payment.

“(g) The Secretary may exempt a person from paying a fee or charge established under this section if the Secretary determines that it is in the public interest to do so.

“(h) Fees and charges collected by the Secretary under this section shall be deposited in the general fund of the Treasury as offsetting receipts of the department in which the Coast Guard is operating and ascribed to Coast Guard activities.

“(i) The collection of a fee or charge under this section does not alter or expand the functions, powers, responsibilities, or liability of the United States under any law for the performance of services or the provision of a thing of value for which a fee or charge is collected under this section.”.

(b) CLERICAL AMENDMENT.—The analysis of chapter 21 of title 46, United States Code, is amended by striking the item relating to section 2110 and inserting the following:

“2110. Fees.”.

SEC. 10402. TONNAGE DUTIES.

(a) VESSELS ENTERING FROM FOREIGN PORT OR PLACE.—Section 36 of the Act entitled “An Act to provide revenue, equalize duties and encourage the industries of the United States, and for other pur-

poses", approved August 5, 1909,⁷⁶ (36 Stat. 111; 46 App. U.S.C. 121) is amended in the second paragraph—

(1) by striking "two cents per ton, not to exceed in the aggregate ten cents per ton in any one year," and inserting "9 cents per ton, not to exceed in the aggregate 45 cents per ton in any one year, for fiscal years 1991, 1992, 1993, 1994, and 1995, and 2 cents per ton, not to exceed in the aggregate 10 cents per ton in any one year, for each fiscal year thereafter";

(2) by inserting after "Newfoundland," the following: "and on all vessels (except vessels of the United States, recreational vessels, and barges, as those terms are defined in section 2101 of title 46, United States Code) that depart a United States port or place and return to the same port or place without being entered in the United States from another port or place,"; and

(3) by striking "six cents per ton, not to exceed thirty cents per ton per annum," and inserting "27 cents per ton, not to exceed \$1.35 per ton per annum, for fiscal years 1991, 1992, 1993, 1994, and 1995, and 6 cents per ton, not to exceed 30 cents per ton per annum, for each fiscal year thereafter".

(b) **CONFORMING AMENDMENT.**—The Act entitled "An Act concerning tonnage duties on vessels entering otherwise than by sea", approved March 8, 1910 (36 Stat. 234; 46 App. U.S.C. 132), is amended by striking "two cents per ton, not to exceed in the aggregate ten cents per ton in any one year" and inserting "9 cents per ton, not to exceed in the aggregate 45 cents per ton in any one year, for fiscal years 1991, 1992, 1993, 1994, and 1995, and 2 cents per ton, not to exceed in the aggregate 10 cents per ton in any one year, for each fiscal year thereafter".

(c) **OFFSETTING RECEIPTS.**—Increased tonnage charges collected as a result of the amendments made by subsection (a) shall be deposited in the general fund of the Treasury as offsetting receipts of the department in which the Coast Guard is operating and ascribed to Coast Guard activities.

46 USC app. 121
note.

Subtitle F—Railroad User Fees

SEC. 10501. AMENDMENTS TO FEDERAL RAILROAD SAFETY ACT OF 1970.

(a) **USER FEES.**—The Federal Railroad Safety Act of 1970 (45 U.S.C. 431 et seq.) is amended by adding at the end the following new section:

"SEC. 216. USER FEES.

45 USC 447.

"(a)(1) The Secretary shall establish by regulation, after notice and comment, a schedule of fees to be assessed equitably to railroads, in reasonable relationship to an appropriate combination of criteria such as revenue ton-miles, track miles, passenger miles, or other relevant factors, but shall not be based on the proportion of industry revenues attributable to a railroad or class of railroads.

"(2) The Secretary shall establish procedures for the collection of such fees. The Secretary may use the services of any Federal, State, or local agency or instrumentality to collect such fees, and may reimburse such agency or instrumentality a reasonable amount for such services.

"(3) Fees established under this section shall be assessed to railroads subject to this Act and shall cover the costs of administering this Act, other than activities described in section 202(a)(2).

⁷⁶ So in original. Probably should be "1909 (36)".

“(b) The Secretary shall assess and collect fees described in subsection (a) with respect to each fiscal year before the end of such fiscal year.

“(c) All fees collected under subsection (b) shall be deposited into the general fund of the United States Treasury as offsetting receipts and shall be used, to the extent provided in advance in appropriations Acts, only to carry out activities under this Act.

“(d) Fees established under subsection (a) shall be assessed in an amount sufficient to cover activities described in subsection (c) beginning on March 1, 1991, but at no time shall the aggregate of fees received for any fiscal year under this section exceed 105 percent of the aggregate of appropriations made for such fiscal year for activities to be funded by such fees.

“(e)(1) Within 90 days after the end of each fiscal year in which fees are collected pursuant to this section, the Secretary shall report to the Congress—

“(A) the amount of fees collected during that fiscal year;

“(B) the impact of such fee collections on the financial health of the railroad industry and its competitive position relative to each competing mode of transportation; and

“(C) the total cost of Federal safety activities for each such other mode of transportation, including the portion of that total cost, if any, defrayed by Federal user fees.

“(2) With respect to any fiscal year for which the Secretary’s report submitted under paragraph (1) finds—

“(A) any impact of fees collected under this section either on the financial health of the railroad industry, or on its competitive position relative to competing modes of transportation; or

“(B) any significant difference in the burden of Federal user fees borne by the railroad industry and those applicable to competing modes of transportation,

the Secretary shall, within 90 days after submission of such report, prepare and submit to the Congress specific recommendations for legislation to correct any such impact or difference.

“(f) This section shall expire on September 30, 1995.”.

(b) AUTHORIZATION OF APPROPRIATIONS.—Section 214(a) of the Federal Railroad Safety Act of 1970 (45 U.S.C. 444(a)) is amended to read as follows:

“(a) There are authorized to be appropriated to carry out this Act not to exceed \$46,884,000 for fiscal year 1991.”.

Revenue
Reconciliation
Act of 1990.

TITLE XI—REVENUE PROVISIONS

SEC. 11001. SHORT TITLE; ETC.

(a) SHORT TITLE.—This title may be cited as the “Revenue Reconciliation Act of 1990”.

(b) AMENDMENT OF 1986 CODE.—Except as otherwise expressly provided, whenever in this title an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Internal Revenue Code of 1986.

(c) SECTION 15 NOT TO APPLY.—Except as otherwise expressly provided in this title, no amendment made by this title shall be treated as a change in a rate of tax for purposes of section 15 of the Internal Revenue Code of 1986.

(d) TABLE OF CONTENTS.—

26 USC 1 note.

26 USC 15 note.

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Subtitle A—Individual Income Tax Provisions**PART I—PROVISIONS AFFECTING HIGH-INCOME INDIVIDUALS****SEC. 11101. ELIMINATION OF PROVISION REDUCING MARGINAL TAX RATE FOR HIGH-INCOME TAXPAYERS.**

(a) **GENERAL RULE.**—Section 1 (relating to tax imposed) is amended by striking subsections (a) through (e) and inserting the following:

“(a) **MARRIED INDIVIDUALS FILING JOINT RETURNS AND SURVIVING SPOUSES.**—There is hereby imposed on the taxable income of—

“(1) every married individual (as defined in section 7703) who makes a single return jointly with his spouse under section 6013, and

“(2) every surviving spouse (as defined in section 2(a)), a tax determined in accordance with the following table:

“If taxable income is:	The tax is:
Not over \$32,450	15% of taxable income.
Over \$32,450 but not over \$78,400	\$4,867.50, plus 28% of the excess over \$32,450.
Over \$78,400	\$17,733.50, plus 31% of the excess over \$78,400.

“(b) **HEADS OF HOUSEHOLDS.**—There is hereby imposed on the taxable income of every head of a household (as defined in section 2(b)) a tax determined in accordance with the following table:

“If taxable income is:		The tax is:
Not over \$26,050		15% of taxable income.
Over \$26,050 but not over \$67,200.....		\$3,907.50, plus 28% of the excess over \$26,500.
Over \$67,200		\$15,429.50, plus 31% of the excess over \$67,200.

“(c) **UNMARRIED INDIVIDUALS (OTHER THAN SURVIVING SPOUSES AND HEADS OF HOUSEHOLDS).**—There is hereby imposed on the taxable income of every individual (other than a surviving spouse as defined in section 2(a) or the head of a household as defined in section 2(b)) who is not a married individual (as defined in section 7703) a tax determined in accordance with the following table:

“If taxable income is:		The tax is:
Not over \$19,450		15% of taxable income.
Over \$19,450 but not over \$47,050.....		\$2,917.50, plus 28% of the excess over \$19,450.
Over \$47,050		\$10,645.50, plus 31% of the excess over \$47,050.

“(d) **MARRIED INDIVIDUALS FILING SEPARATE RETURNS.**—There is hereby imposed on the taxable income of every married individual (as defined in section 7703) who does not make a single return jointly with his spouse under section 6013, a tax determined in accordance with the following table:

“If taxable income is:		The tax is:
Not over \$16,225		15% of taxable income.
Over \$16,225 but not over \$39,200.....		\$2,433.75, plus 28% of the excess over \$16,225.
Over \$39,200		\$8,866.75, plus 31% of the excess over \$39,200.

“(e) **ESTATES AND TRUSTS.**—There is hereby imposed on the taxable income of—

- “(1) every estate, and
- “(2) every trust,

taxable under this subsection a tax determined in accordance with the following table:

“If taxable income is:		The tax is:
Not over \$3,300		15% of taxable income.
Over \$3,300 but not over \$9,900.....		\$495, plus 28% of the excess over \$3,300.
Over \$9,900		\$2,343, plus 31% of the excess over \$9,900.”

(b) **REPEAL OF PHASEOUT.**—

(1) **IN GENERAL.**—Section 1 is amended by striking subsection (g) (relating to phaseout of 15-percent rate and personal exemptions).

(2) **CONFORMING AMENDMENT.**—Subparagraph (A) of section 1(f)(6) (relating to adjustments for inflation) is amended by striking “subsection (g)(4).”

(c) **28 PERCENT MAXIMUM CAPITAL GAINS RATE.**—Subsection (j) of section 1 (relating to maximum capital gains rate) is amended to read as follows:

“(j) **MAXIMUM CAPITAL GAINS RATE.**—If a taxpayer has a net capital gain for any taxable year, then the tax imposed by this section shall not exceed the sum of—

- “(1) a tax computed at the rates and in the same manner as if this subsection had not been enacted on the greater of—

“(A) taxable income reduced by the amount of the net capital gain, or

“(B) the amount of taxable income taxed at a rate below 28 percent, plus

“(2) a tax of 28 percent of the amount of taxable income in excess of the amount determined under paragraph (1).”

(d) TECHNICAL AMENDMENTS.—

(1)(A) Subsection (f) of section 1 is amended—

(i) by striking “1988” in paragraph (1) and inserting “1990”, and

(ii) by striking “1987” in paragraph (3)(B) and inserting “1989”.

(B) Subparagraph (B) of section 32(i)(1) is amended by striking “1987” and inserting “1989”.

(C) Subparagraph (C) of section 41(e)(5) is amended—

(i) by inserting “, by substituting ‘calendar year 1987’ for ‘calendar year 1989’ in subparagraph (B) thereof” before the period at the end of clause (i),

(ii) by striking “1987” in clause (ii) and inserting “1989”, and

(iii) by adding at the end of clause (ii) the following new sentence: “Such substitution shall be in lieu of the substitution under clause (i).”.

(D) Subparagraph (B) of section 63(c)(4) is amended by inserting “, by substituting ‘calendar year 1987’ for ‘calendar year 1989’ in subparagraph (B) thereof” before the period at the end.

(E) Clause (ii) of section 135(b)(2)(B) is amended by striking “, determined by substituting ‘calendar year 1989’ for ‘calendar year 1987’ in subparagraph (B) thereof”.

(F) Subparagraph (B) of section 151(d)(3) is amended by striking “1987” and inserting “1989”.

(G) Clause (ii) of section 513(h)(2)(C) is amended by inserting “, by substituting ‘calendar year 1987’ for ‘calendar year 1989’ in subparagraph (B) thereof” before the period at the end.

(2) Section 1 is amended by striking subsection (h) and redesignating subsections (i) and (j) as subsections (g) and (h), respectively.

(3) Subsection (j) of section 59 is amended—

(A) by striking “section 1(i)” each place it appears and inserting “section 1(g)”, and

(B) by striking “section 1(i)(3)(B)” in paragraph (2)(C) and inserting “section 1(g)(3)(B)”.

(4) Paragraph (4) of section 691(c) is amended by striking “1(j)” and inserting “1(h)”.

(5)(A) Clause (i) of section 904(b)(3)(D) is amended by striking “subsection (j)” and inserting “subsection (h)”.

(B) Subclause (I) of section 904(b)(3)(E)(iii) is amended by striking “section 1(j)” and inserting “section 1(h)”.

(6) Clause (iv) of section 6103(e)(1)(A) is amended by striking “section 1(j)” and inserting “section 1(g)”.

(7)(A) Subparagraph (A) of section 7518(g)(6) is amended by striking “1(j)” and inserting “1(h)”.

(B) Subparagraph (A) of section 607(h)(6) of the Merchant Marine Act, 1936 is amended by striking “1(j)” and inserting “1(h)”.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1990.

46 USC app.
1177.

26 USC 1 note.

SEC. 11102. INCREASE IN RATE OF INDIVIDUAL ALTERNATIVE MINIMUM TAX.

(a) **GENERAL RULE.**—Subparagraph (A) of section 55(b)(1) (relating to tentative minimum tax) is amended by striking “21 percent” and inserting “24 percent”.

26 USC 55 note.

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall apply to taxable years beginning after December 31, 1990.

SEC. 11103. OVERALL LIMITATION ON ITEMIZED DEDUCTIONS.

(a) **IN GENERAL.**—Part I of subchapter B of chapter 1 is amended by adding at the end thereof the following new section:

“SEC. 68. OVERALL LIMITATION ON ITEMIZED DEDUCTIONS.

“(a) GENERAL RULE.—In the case of an individual whose adjusted gross income exceeds the applicable amount, the amount of the itemized deductions otherwise allowable for the taxable year shall be reduced by the lesser of—

“(1) 3 percent of the excess of adjusted gross income over the applicable amount, or

“(2) 80 percent of the amount of the itemized deductions otherwise allowable for such taxable year.

“(b) APPLICABLE AMOUNT.—

“(1) **IN GENERAL.**—For purposes of this section, the term ‘applicable amount’ means \$100,000 (\$50,000 in the case of a separate return by a married individual within the meaning of section 7703).

“(2) **INFLATION ADJUSTMENTS.**—In the case of any taxable year beginning in a calendar year after 1991, each dollar amount contained in paragraph (1) shall be increased by an amount equal to—

“(A) such dollar amount, multiplied by

“(B) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins, by substituting ‘calendar year 1990’ for ‘calendar year 1989’ in subparagraph (B) thereof.”

“(c) EXCEPTION FOR CERTAIN ITEMIZED DEDUCTIONS.—For purposes of this section, the term ‘itemized deductions’ does not include—

“(1) the deduction under section 213 (relating to medical, etc. expenses),

“(2) any deduction for investment interest (as defined in section 163(d)), and

“(3) the deduction under section 165(a) for losses described in subsection (c)(3) or (d) of section 165.

“(d) COORDINATION WITH OTHER LIMITATIONS.—This section shall be applied after the application of any other limitation on the allowance of any itemized deduction.

“(e) EXCEPTION FOR ESTATES AND TRUSTS.—This section shall not apply to any estate or trust.

“(f) TERMINATION.—This section shall not apply to any taxable year beginning after December 31, 1995.”

(b) **COORDINATION WITH MINIMUM TAX.**—Paragraph (1) of section 56(b) is amended by adding at the end thereof the following new subparagraph:

“(F) SECTION 68 NOT APPLICABLE.—Section 68 shall not apply.”

(c) **CONFORMING AMENDMENT.**—Subparagraph (A) of section 1(f)(6) is amended by inserting “section 68(b)(2)” after “section 63(c)(4),”

(d) **CLERICAL AMENDMENT.**—The table of sections for part I of subchapter B of chapter 1 is amended by adding a ⁷⁷ the end thereof the following new item:

“Sec. 68. Overall limitation on itemized deductions.”

(e) **EFFECTIVE DATE.**—The amendments made by this section shall apply to taxable years beginning after December 31, 1990. 26 USC 1 note.

SEC. 11104. PHASEOUT OF PERSONAL EXEMPTIONS.

(a) **GENERAL RULE.**—Subsection (d) of section 151 is amended to read as follows:

“(d) **EXEMPTION AMOUNT.**—For purposes of this section—

“(1) **IN GENERAL.**—Except as otherwise provided in this subsection, the term ‘exemption amount’ means \$2,000.

“(2) **EXEMPTION AMOUNT DISALLOWED IN CASE OF CERTAIN DEPENDENTS.**—In the case of an individual with respect to whom a deduction under this section is allowable to another taxpayer for a taxable year beginning in the calendar year in which the individual’s taxable year begins, the exemption amount applicable to such individual for such individual’s taxable year shall be zero.

“(3) **PHASEOUT.**—

“(A) **IN GENERAL.**—In the case of any taxpayer whose adjusted gross income for the taxable year exceeds the threshold amount, the exemption amount shall be reduced by the applicable percentage.

“(B) **APPLICABLE PERCENTAGE.**—For purposes of subparagraph (A), the term ‘applicable percentage’ means 2 percentage points for each \$2,500 (or fraction thereof) by which the taxpayer’s adjusted gross income for the taxable year exceeds the threshold amount. In the case of a married individual filing a separate return, the preceding sentence shall be applied by substituting ‘\$1,250’ for ‘\$2,500’. In no event shall the applicable percentage exceed 100 percent.

“(C) **THRESHOLD AMOUNT.**—For purposes of this paragraph, the term ‘threshold amount’ means—

“(i) \$150,000 in the case of a joint of a return or a surviving spouse (as defined in section 2(a)),

“(ii) \$125,000 in the case of a head of a household (as defined in section 2(b)) ⁷⁸,

“(iii) \$100,000 in the case of an individual who is not married and who is not a surviving spouse or head of a household, and

“(iv) \$75,000 in the case of a married individual filing a separate return.

For purposes of this paragraph, marital status shall be determined under section 7703.

“(D) **COORDINATION WITH OTHER PROVISIONS.**—The provisions of this paragraph shall not apply for purposes of determining whether a deduction under this section with respect to any individual is allowable to another taxpayer for any taxable year.

“(E) **TERMINATION.**—This paragraph shall not apply to any taxable year beginning after December 31, 1995.

“(4) **INFLATION ADJUSTMENTS.**—

“(A) **ADJUSTMENT TO BASIC AMOUNT OF EXEMPTION.**—In the case of any taxable year beginning in a calendar year

⁷⁷ So in original. Probably should be “at”.

⁷⁸ So in original. Probably should be “2(b))”.

after 1989, the dollar amount contained in paragraph (1) shall be increased by an amount equal to—

“(i) such dollar amount, multiplied by

“(ii) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins, by substituting ‘calendar year 1988’ for ‘calendar year 1989’ in subparagraph (B) thereof.

“(B) ADJUSTMENT TO THRESHOLD AMOUNTS FOR YEARS AFTER 1991.—In the case of any taxable year beginning in a calendar year after 1991, each dollar amount contained in paragraph (3)(C) shall be increased by an amount equal to—

“(i) such dollar amount, multiplied by

“(ii) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins, by substituting ‘calendar year 1990’ for ‘calendar year 1989’ in subparagraph (B) thereof.”

(b) CONFORMING AMENDMENT.—Paragraph (6) of section 1(f) is amended—

(1) by striking “section 151(d)(3)” in subparagraph (A) and inserting “section 151(d)(4)”, and

(2) by striking “section 151(d)(3)” in subparagraph (B) and inserting “section 151(d)(4)(A)”.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1990.

PART II—MODIFICATIONS OF EARNED INCOME CREDIT

SEC. 11111. MODIFICATIONS OF EARNED INCOME TAX CREDIT.

(a) IN GENERAL.—So much of section 32 (relating to earned income credit) as precedes subsection (d) thereof is amended to read as follows:

“SEC. 32. EARNED INCOME.

“(a) ALLOWANCE OF CREDIT.—In the case of an eligible individual, there shall be allowed as a credit against the tax imposed by this subtitle for the taxable year an amount equal to the sum of—

“(1) the basic earned income credit, and

“(2) the health insurance credit.

“(b) COMPUTATION OF CREDIT.—For purposes of this section—

“(1) BASIC EARNED INCOME CREDIT.—

“(A) IN GENERAL.—The term ‘basic earned income credit’ means an amount equal to the credit percentage of so much of the taxpayer’s earned income for the taxable year as does not exceed \$5,714.

“(B) LIMITATION.—The amount of the basic earned income credit allowable to a taxpayer for any taxable year shall not exceed the excess (if any) of—

“(i) the credit percentage of \$5,714, over

“(ii) the phaseout percentage of so much of the adjusted gross income (or, if greater the earned income) of the taxpayer for the taxable year as exceeds \$9,000.

“(C) PERCENTAGES.—For purposes of this paragraph—

“(i) IN GENERAL.—Except as provided in clause (ii), the percentages shall be determined as follows:

"In the case of an eligible individual with:	The credit percentage is:	The phaseout percentage is:
1 qualifying child.....	23	16.43
2 or more qualifying children	25	17.86

“(ii) TRANSITION PERCENTAGES.—

“(I) For taxable years beginning in 1991, the percentages are:

"In the case of an eligible individual with:	The credit percentage is:	The phaseout percentage is:
1 qualifying child.....	16.7	11.93
2 or more qualifying children	17.3	12.36

“(II) For taxable years beginning in 1992, the percentages are:

"In the case of an eligible individual with:	The credit percentage is:	The phaseout percentage is:
1 qualifying child.....	17.6	12.57
2 or more qualifying children	18.4	13.14

“(III) For taxable years beginning in 1993, the percentages are:

"In the case of an eligible individual with:	The credit percentage is:	The phaseout percentage is:
1 qualifying child.....	18.5	13.21
2 or more qualifying children	19.5	13.93

“(D) SUPPLEMENTAL YOUNG CHILD CREDIT.—In the case of a taxpayer with a qualifying child who has not attained age 1 as of the close of the calendar year in which or with which the taxable year of the taxpayer ends—

“(i) the credit percentage shall be increased by 5 percentage points, and

“(ii) the phaseout percentage shall be increased by 3.57 percentage points.

If the taxpayer elects to take a child into account under this subparagraph, such child shall not be treated as a qualifying individual under section 21.

“(2) HEALTH INSURANCE CREDIT.—

“(A) IN GENERAL.—The term ‘health insurance credit’ means an amount determined in the same manner as the basic earned income credit except that—

“(i) the credit percentage shall be equal to 6 percent, and

“(ii) the phaseout percentage shall be equal to 4.285 percent.

“(B) LIMITATION BASED ON HEALTH INSURANCE COSTS.—The amount of the health insurance credit determined under subparagraph (A) for any taxable year shall not exceed the amounts paid by the taxpayer during the taxable year for insurance coverage—

“(i) which constitutes medical care (within the meaning of section 213(d)(1)(C)), and

“(ii) which includes at least 1 qualifying child.

For purposes of this subparagraph, the rules of section 213(d)(6) shall apply.

“(C) SUBSIDIZED EXPENSES.—A taxpayer may not take into account under subparagraph (B) any amount to the extent that—

“(i) such amount is paid, reimbursed, or subsidized by the Federal Government, a State or local government, or any agency or instrumentality thereof; and

“(ii) the payment, reimbursement, or subsidy of such amount is not includible in the gross income of the recipient.

“(c) DEFINITIONS AND SPECIAL RULES.—For purposes of this section—

“(1) ELIGIBLE INDIVIDUAL.—

“(A) IN GENERAL.—The term ‘eligible individual’ means any individual who has a qualifying child for the taxable year.

“(B) QUALIFYING CHILD INELIGIBLE.—If an individual is the qualifying child of a taxpayer for any taxable year of such taxpayer beginning in a calendar year, such individual shall not be treated as an eligible individual for any taxable year of such individual beginning in such calendar year.

“(C) 2 OR MORE ELIGIBLE INDIVIDUALS.—If 2 or more individuals would (but for this subparagraph and after application of subparagraph (B)) be treated as eligible individuals with respect to the same qualifying child for taxable years beginning in the same calendar year, only the individual with the highest adjusted gross income for such taxable years shall be treated as an eligible individual with respect to such qualifying child.

“(D) EXCEPTION FOR INDIVIDUAL CLAIMING BENEFITS UNDER SECTION 911.—The term ‘eligible individual’ does not include any individual who claims the benefits of section 911 (relating to citizens or residents living abroad) for the taxable year.

“(2) EARNED INCOME.—

“(A) The term ‘earned income’ means—

“(i) wages, salaries, tips, and other employee compensation, plus

“(ii) the amount of the taxpayer’s net earnings from self-employment for the taxable year (within the meaning of section 1402(a)), but such net earnings shall be determined with regard to the deduction allowed to the taxpayer by section 164(f).

“(B) For purposes of subparagraph (A)—

“(i) the earned income of an individual shall be computed without regard to any community property laws,

“(ii) no amount received as a pension or annuity shall be taken into account, and

“(iii) no amount to which section 871(a) applies (relating to income of nonresident alien individuals not connected with United States business) shall be taken into account.

“(3) QUALIFYING CHILD.—

“(A) IN GENERAL.—The term ‘qualifying child’ means, with respect to any taxpayer for any taxable year, an individual—

“(i) who bears a relationship to the taxpayer described in subparagraph (B),

“(ii) except as provided in subparagraph (B)(iii), who has the same principal place of abode as the taxpayer for more than one-half of such taxable year,

“(iii) who meets the age requirements of subparagraph (C), and

“(iv) with respect to whom the taxpayer meets the identification requirements of subparagraph (D).

“(B) RELATIONSHIP TEST.—

“(i) IN GENERAL.—An individual bears a relationship to the taxpayer described in this subparagraph if such individual is—

“(I) a son or daughter of the taxpayer, or a descendant of either,

“(II) a stepson or stepdaughter of the taxpayer, or

“(III) an eligible foster child of the taxpayer.

“(ii) MARRIED CHILDREN.—Clause (i) shall not apply to any individual who is married as of the close of the taxpayer’s taxable year unless the taxpayer is entitled to a deduction under section 151 for such taxable year with respect to such individual (or would be so entitled but for paragraph (2) or (4) of section 152(e)).

“(iii) ELIGIBLE FOSTER CHILD.—For purposes of clause (i)(III), the term ‘eligible foster child’ means an individual not described in clause (i) (I) or (II) who—

“(I) the taxpayer cares for as the taxpayer’s own child, and

“(II) has the same principal place of abode as the taxpayer for the taxpayer’s entire taxable year.

“(iv) ADOPTION.—For purposes of this subparagraph, a child who is legally adopted, or who is placed with the taxpayer by an authorized placement agency for adoption by the taxpayer, shall be treated as a child by blood.

“(C) AGE REQUIREMENTS.—An individual meets the requirements of this subparagraph if such individual—

“(i) has not attained the age of 19 as of the close of the calendar year in which the taxable year of the taxpayer begins,

“(ii) is a student (as defined in section 151(c)(4)) who has not attained the age of 24 as of the close of such calendar year, or

“(iii) is permanently and totally disabled (as defined in section 22(e)(3)) at any time during the taxable year.

“(D) IDENTIFICATION REQUIREMENTS.—

“(i) IN GENERAL.—The requirements of this subparagraph are met if—

“(I) the taxpayer includes the name and age of each qualifying child (without regard to this subparagraph) on the return of tax for the taxable year, and

“(II) in the case of an individual who has attained the age of 1 year before the close of the taxpayer’s taxable year, the taxpayer includes the taxpayer identification number of such individual on such return of tax for such taxable year.

“(ii) INSURANCE POLICY NUMBER.—In the case of any taxpayer with respect to which the health insurance credit is allowed under subsection (a)(2), the Secretary may require a taxpayer to include an insurance policy

number or other adequate evidence of insurance in addition to any information required to be included in clause (i).

“(iii) OTHER METHODS.—The Secretary may prescribe other methods for providing the information described in clause (i) or (ii).

“(E) ABODE MUST BE IN THE UNITED STATES.—The requirements of subparagraphs (A)(ii) and (B)(iii)(II) shall be met only if the principal place of abode is in the United States.”

(b) COORDINATION WITH CERTAIN MEANS-TESTED PROGRAMS.—Section 32 is amended by adding at the end thereof the following new subsection:

“(j) COORDINATION WITH CERTAIN MEANS-TESTED PROGRAMS.—For purposes of—

“(1) the United States Housing Act of 1937,

“(2) title V of the Housing Act of 1949,

“(3) section 101 of the Housing and Urban Development Act of 1965,

“(4) sections 221(d)(3), 235, and 236 of the National Housing Act, and

“(5) the Food Stamp Act of 1977,

any refund made to an individual (or the spouse of an individual) by reason of this section, and any payment made to such individual (or such spouse) by an employer under section 3507, shall not be treated as income (and shall not be taken into account in determining resources for the month of its receipt and the following month).”

(c) ADVANCE PAYMENT OF CREDIT.—Subparagraphs (B) and (C) of section 3507(c)(2) are amended to read as follows:

“(B) if the employee is not married, or if no earned income eligibility certificate is in effect with respect to the spouse of the employee, shall treat the credit provided by section 32 as if it were a credit—

“(i) of not more than the credit percentage under section 32(b)(1) (without regard to subparagraph (D) thereof) for an eligible individual with 1 qualifying child and with earned income not in excess of the amount of earned income taken into account under section 32(a)(1), which

“(ii) phases out between the amount of earned income at which the phaseout begins under section 32(b)(1)(B)(ii) and the amount of income at which the credit under section 32(a)(1) phases out for an eligible individual with 1 qualifying child, or

“(C) if an earned income eligibility certificate is in effect with respect to the spouse of the employee, shall treat the credit as if it were a credit determined under subparagraph (B) by substituting $\frac{1}{2}$ of the amounts of earned income described in such subparagraph for such amounts.”

(d) COORDINATION WITH DEDUCTIONS.—

(1) MEDICAL DEDUCTION.—Section 213 is amended by adding at the end thereof the following new subsection:

“(f) COORDINATION WITH HEALTH INSURANCE CREDIT UNDER SECTION 32.—The amount otherwise taken into account under subsection (a) as expenses paid for medical care shall be reduced by the amount (if any) of the health insurance credit allowable to the taxpayer for the taxable year under section 32.”

(2) SELF-EMPLOYED INDIVIDUALS.—Paragraph (3) of section 162(1) is amended to read as follows:

“(3) COORDINATION WITH MEDICAL DEDUCTION, ETC.—

“(A) MEDICAL DEDUCTION.—Any amount paid by a taxpayer for insurance to which paragraph (1) applies shall not be taken into account in computing the amount allowable to the taxpayer as a deduction under section 213(a).

“(B) HEALTH INSURANCE CREDIT.—The amount otherwise taken into account under paragraph (1) as paid for insurance which constitutes medical care shall be reduced by the amount (if any) of the health insurance credit allowable to the taxpayer for the taxable year under section 32.”

(e) CONFORMING AMENDMENTS.—Paragraph (2) of section 32(i) is amended—

(1) by striking “or (ii)” in subparagraph (A)(i) thereof,

(2) by striking “clause (iii)” in subparagraph (A)(ii) and inserting “clause (ii)”, and

(3) by amending subparagraph (B) to read as follows:

“(B) DOLLAR AMOUNTS.—The dollar amounts referred to in this subparagraph are—

“(i) the \$5,714 dollar amounts contained in subsection (b)(1), and

“(ii) the \$9,000 amount contained in subsection (b)(1)(B)(ii).”

(f) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1990.

26 USC 32 note.

SEC. 11112. REQUIREMENT OF IDENTIFYING NUMBER FOR CERTAIN DEPENDENTS.

(a) GENERAL RULE.—Paragraph (2) of section 6109(e) (relating to furnishing number for certain dependents) is amended by striking “2 years” and inserting “1 year”.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to returns for taxable years beginning after December 31, 1990.

26 USC 6109 note.

SEC. 11113. STUDY OF ADVANCE PAYMENTS.

26 USC 3507 note.

(a) IN GENERAL.—The Comptroller General of the United States shall, in consultation with the Secretary of the Treasury, conduct a study of advance payments required by section 3507 of the Internal Revenue Code of 1986 to determine—

(1) the effectiveness of the advance payment system (including an analysis of why so few employees take advantage of such system), and

(2) the manner in which such system can be implemented to alleviate administrative complexity, if any, for small business, and

(3) if there are any other problems in the administration of such system.

(b) REPORT.—Not later than 1 year after the date of the enactment of this title, the Comptroller shall report the results of the study conducted under subsection (a), together with any recommendations, to the Committee on Finance of the United States Senate and the Committee on Ways and Means of the House of Representatives.

26 USC 21 note.

SEC. 11114. PROGRAM TO INCREASE PUBLIC AWARENESS.

Not later than the first calendar year following the date of the enactment of this subtitle, the Secretary of the Treasury, or the Secretary's delegate, shall establish a taxpayer awareness program to inform the taxpaying public of the availability of the credit for dependent care allowed under section 21 of the Internal Revenue Code of 1986 and the earned income credit and child health insurance under section 32 of such Code. Such public awareness program shall be designed to assure that individuals who may be eligible are informed of the availability of such credit and filing procedures. The Secretary shall use appropriate means of communication to carry out the provisions of this section.

SEC. 11115. EXCLUSION FROM INCOME AND RESOURCES OF EARNED INCOME TAX CREDIT UNDER TITLES IV, XVI, AND XIX OF THE SOCIAL SECURITY ACT.**(a) EXCLUSIONS UNDER TITLE IV.—**

(1) **EXCLUSIONS FROM RESOURCES.**—Section 402(a)(7)(B) of the Social Security Act (42 U.S.C. 602(a)(7)(B)) is amended—

(A) by striking “or” before “(iii)”; and

(B) by inserting “, or (iv) for the month of receipt and the following month, any refund of Federal income taxes made to such family by reason of section 32 of the Internal Revenue Code of 1986 (relating to earned income credit), and any payment made to such family by an employer under section 3507 of such Code (relating to advance payment of earned income credit)” before the semicolon.

(2) **EXCLUSIONS FROM INCOME.**—Section 402(a)(18) of the Social Security Act (42 U.S.C. 602(a)(18)) is amended by inserting “or 8(A)(viii)” after “other than paragraph 8(A)(v)”

(b) EXCLUSIONS UNDER TITLE XVI.—

(1) **EXCLUSIONS FROM INCOME.**—Section 1612(b) of the Social Security Act (42 U.S.C. 1382a(b)), as amended by sections 5031(a) and 5035(a) of this Act, is amended—

(A) by striking “and” at the end of paragraph (17);

(B) by striking the period at the end of paragraph (18) and inserting “; and”; and

(C) by adding at the end the following:

“(19) any refund of Federal income taxes made to such individual (or such spouse) by reason of section 32 of the Internal Revenue Code of 1986 (relating to earned income tax credit), and any payment made to such individual (or such spouse) by an employer under section 3507 of such Code (relating to advance payment of earned income credit).”

(2) **EXCLUSIONS FROM RESOURCES.**—Section 1613(a) of the Social Security Act (42 U.S.C. 1382b(a)), as amended by sections 5031(b) and 5035(b) of this Act, is amended—

(A) by striking “and” at the end of paragraph (8);

(B) by striking the period at the end of paragraph (9) and inserting “; and”; and

(C) by adding at the end the following new paragraph:

“(10) for the month of receipt and the following month, any refund of Federal income taxes made to such individual (or such spouse) by reason of section 32 of the Internal Revenue Code of 1986 (relating to earned income tax credit), and any payment made to such individual (or such spouse) by an employer under

section 3507 of such Code (relating to advance payment of earned income credit).”.

(c) **EXCLUSIONS UNDER TITLE XIX.**—Pursuant to section 1902(a)(17) of the Social Security Act (42 U.S.C. 1396a(a)(17)), the Secretary of Health and Human Services shall promulgate regulations to exempt from any determination of income and resources (for the month of receipt and the following month) under title XIX of the Social Security Act any refund of Federal income taxes made to an individual by reason of section 32 of the Internal Revenue Code of 1986 (relating to earned income tax credit), and any payment made to an individual by an employer under section 3507 of such Code (relating to advance payment of earned income credit).

42 USC 1396a
note.

(d) **AFDC WAIVER OF OVERPAYMENT.**—For the purposes of section 402(a)(18) of the Social Security Act (42 U.S.C. 602(a)(18)), a State agency designated under a State plan under section 402(a)(3) of such Act may waive any overpayment of aid that resulted from the receipt by a family of a refund of Federal income taxes by reason of section 32 of the Internal Revenue Code of 1986 (relating to earned income tax credit) or any payment made to such family by an employer under section 3507 of such Code (relating to advance payment of earned income credit) during the period beginning on January 1, 1990, and ending on December 31, 1990.

42 USC 602 note.

(e) **EFFECTIVE DATE.**—The amendments made by subsections (a) through ⁷⁹ (c) shall apply to determinations of income or resources made for any period after December 31, 1990.

42 USC 602 note.

SEC. 11116. COORDINATION WITH REFUND PROVISION.

31 USC 1324
note.

For purposes of section 1324(b)(2) of title 31 of the United States Code, section 32 of the Internal Revenue Code of 1986 (as amended by this Act) shall be considered to be a credit provision of the Internal Revenue Code of 1954 enacted before January 1, 1978.

Subtitle B—Excise Taxes

PART I—TAXES RELATED TO HEALTH AND THE ENVIRONMENT

SEC. 11201. INCREASE IN EXCISE TAXES ON DISTILLED SPIRITS, WINE, AND BEER.

(a) DISTILLED SPIRITS.—

(1) **IN GENERAL.**—Paragraphs (1) and (3) of section 5001(a) (relating to rate of tax on distilled spirits) are each amended by striking “\$12.50” and inserting “\$13.50”.

(2) **TECHNICAL AMENDMENT.**—Paragraphs (1) and (2) of section 5010(a) (relating to credit for wine content and for flavors content) are each amended by striking “\$12.50” and inserting “\$13.50”.

(b) WINE.—

(1) TAX INCREASES.—

(A) **WINES CONTAINING NOT MORE THAN 14 PERCENT ALCOHOL.**—Paragraph (1) of section 5041(b) (relating to rates of tax on wines) is amended by striking “17 cents” and inserting “\$1.07”.

(B) **WINES CONTAINING MORE THAN 14 (BUT NOT MORE THAN 21) PERCENT ALCOHOL.**—Paragraph (2) of section

⁷⁹ So in original. Probably should be “through”.

satisfaction of any indebtedness if such issuance or transfer (as the case may be)—

(A) is in a title 11 or similar case (as defined in section 368(a)(3)(A) of the Internal Revenue Code of 1986) which was filed on or before October 9, 1990,

(B) is pursuant to a written binding contract in effect on October 9, 1990, and at all times thereafter before such issuance or transfer,

(C) is pursuant to a transaction which was described in documents filed with the Securities and Exchange Commission on or before October 9, 1990, or

(D) is pursuant to a transaction—

(i) the material terms of which were described in a written public announcement on or before October 9, 1990,

(ii) which was the subject of a prior filing with the Securities and Exchange Commission, and

(iii) which is the subject of a subsequent filing with the Securities and Exchange Commission before January 1, 1991.

PART IV—EMPLOYMENT TAX PROVISIONS

SEC. 11331. INCREASE IN DOLLAR LIMITATION ON AMOUNT OF WAGES SUBJECT TO HOSPITAL INSURANCE TAX.

(a) HOSPITAL INSURANCE TAX.—

(1) IN GENERAL.—Paragraph (1) of section 3121(a) is amended—

(A) by striking “contribution and benefit base (as determined under section 230 of the Social Security Act)” each place it appears and inserting “applicable contribution base (as determined under subsection (x))”, and

(B) by striking “such contribution and benefit base” and inserting “such applicable contribution base”.

(2) APPLICABLE CONTRIBUTION BASE.—Section 3121 is amended by adding at the end thereof the following new subsection:

“(x) APPLICABLE CONTRIBUTION BASE.—For purposes of this chapter—

“(1) OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE.—For purposes of the taxes imposed by sections 3101(a) and 3111(a), the applicable contribution base for any calendar year is the contribution and benefit base determined under section 230 of the Social Security Act for such calendar year.

“(2) HOSPITAL INSURANCE.—For purposes of the taxes imposed by section 3101(b) and 3111(b), the applicable contribution base is—

“(A) \$125,000 for calendar year 1991, and

“(B) for any calendar year after 1991, the applicable contribution base for the preceding year adjusted in the same manner as is used in adjusting the contribution and benefit base under section 230(b) of the Social Security Act.”

(b) SELF-EMPLOYMENT TAX.—

(1) IN GENERAL.—Subsection (b) of section 1402 is amended by striking “the contribution and benefit base (as determined under section 230 of the Social Security Act)” and inserting “the

applicable contribution base (as determined under subsection (k))”.

(2) **APPLICABLE CONTRIBUTION BASE.**—Section 1402 is amended by adding at the end thereof the following new subsection:
“(k) **APPLICABLE CONTRIBUTION BASE.**—For purposes of this chapter—

“(1) **OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE.**—For purposes of the tax imposed by section 1401(a), the applicable contribution base for any calendar year is the contribution and benefit base determined under section 230 of the Social Security Act for such calendar year.

“(2) **HOSPITAL INSURANCE.**—For purposes of the tax imposed by section 1401(b), the applicable contribution base for any calendar year is the applicable contribution base determined under section 3121(x)(2) for such calendar year.”

(c) **RAILROAD RETIREMENT TAX.**—Clause (i) of section 3231(e)(2)(B) is amended to read as follows:

“(i) **TIER 1 TAXES.**—

“(I) **IN GENERAL.**—Except as provided in subclause (II) of this clause and in clause (ii), the term ‘applicable base’ means for any calendar year the contribution and benefit base determined under section 230 of the Social Security Act for such calendar year.

“(II) **HOSPITAL INSURANCE TAXES.**—For purposes of applying so much of the rate applicable under section 3201(a) or 3221(a) (as the case may be) as does not exceed the rate of tax in effect under section 3101(b), and for purposes of applying so much of the rate of tax applicable under section 3211(a)(1) as does not exceed the rate of tax in effect under section 1401(b), the term ‘applicable base’ means for any calendar year the applicable contribution base determined under section 3121(x)(2) for such calendar year.”

(d) **TECHNICAL AMENDMENT.**—

(1) Paragraph (3) of section 6413(c) is amended to read as follows:

“(3) **SEPARATE APPLICATION FOR HOSPITAL INSURANCE TAXES.**—In applying this subsection with respect to—

“(A) the tax imposed by section 3101(b) (or any amount equivalent to such tax), and

“(B) so much of the tax imposed by section 3201 as is determined at a rate not greater than the rate in effect under section 3101(b),

the applicable contribution base determined under section 3121(x)(2) for any calendar year shall be substituted for ‘contribution and benefit base (as determined under section 230 of the Social Security Act)’ each place it appears.”

(2) Sections 3122 and 3125 are each amended by striking “contribution and benefit base limitation” each place it appears and inserting “applicable contribution base limitation”.

(e) **EFFECTIVE DATE.**—The amendments made by this section shall apply to 1991 and later calendar years.

SEC. 11332. COVERAGE OF CERTAIN STATE AND LOCAL EMPLOYEES UNDER SOCIAL SECURITY.

(a) **EMPLOYMENT UNDER OASDI.**—Paragraph (7) of section 210(a) of the Social Security Act (42 U.S.C. 410(a)(7)) is amended—

- (1) by striking “or” at the end of subparagraph (D);
- (2) by striking the semicolon at the end of subparagraph (E) and inserting “, or”; and

- (3) by adding at the end the following new subparagraph:

“(F) service in the employ of a State (other than the District of Columbia, Guam, or American Samoa), of any political subdivision thereof, or of any instrumentality of any one or more of the foregoing which is wholly owned thereby, by an individual who is not a member of a retirement system of such State, political subdivision, or instrumentality, except that the provisions of this subparagraph shall not be applicable to service performed—

“(i) by an individual who is employed to relieve such individual from unemployment;

“(ii) in a hospital, home, or other institution by a patient or inmate thereof;

“(iii) by any individual as an employee serving on a temporary basis in case of fire, storm, snow, earthquake, flood, or other similar emergency;

“(iv) by an election official or election worker if the remuneration paid in a calendar year for such service is less than \$100; or

“(v) by an employee in a position compensated solely on a fee basis which is treated pursuant to section 211(c)(2)(E) as a trade or business for purposes of inclusion of such fees in net earnings from self employment; for purposes of this subparagraph, except as provided in regulations prescribed by the Secretary of the Treasury, the term ‘retirement system’ has the meaning given such term by section 218(b)(4);”.

(b) **EMPLOYMENT UNDER FICA.**—Paragraph (7) of section 3121(b) of the Internal Revenue Code of 1986 is amended—

- (1) by striking “or” at the end of subparagraph (D);
- (2) by striking the semicolon at the end of subparagraph (E) and inserting “, or”; and

- (3) by adding at the end the following new subparagraph:

“(F) service in the employ of a State (other than the District of Columbia, Guam, or American Samoa), of any political subdivision thereof, or of any instrumentality of any one or more of the foregoing which is wholly owned thereby, by an individual who is not a member of a retirement system of such State, political subdivision, or instrumentality, except that the provisions of this subparagraph shall not be applicable to service performed—

“(i) by an individual who is employed to relieve such individual from unemployment;

“(ii) in a hospital, home, or other institution by a patient or inmate thereof;

“(iii) by any individual as an employee serving on a temporary basis in case of fire, storm, snow, earthquake, flood, or other similar emergency;

“(iv) by an election official or election worker if the remuneration paid in a calendar year for such service is less than \$100; or

“(v) by an employee in a position compensated solely on a fee basis which is treated pursuant to section 1402(c)(2)(E) as a trade or business for purposes of inclusion of such fees in net earnings from self-employment;

for purposes of this subparagraph, except as provided in regulations prescribed by the Secretary, the term ‘retirement system’ has the meaning given such term by section 218(b)(4) of the Social Security Act;”.

(c) **MANDATORY EXCLUSION OF CERTAIN EMPLOYEES FROM STATE AGREEMENTS.**—Section 218(c)(6) of the Social Security Act (42 U.S.C. 418(c)(6)) is amended—

(1) by striking “and” at the end of subparagraph (D);

(2) by striking the period at the end of subparagraph (E) and inserting in lieu thereof “, and”; and

(3) by adding at the end the following new subparagraph:

“(F) service described in section 210(a)(7)(F) which is included as ‘employment’ under section 210(a).”.

(d) **EFFECTIVE DATE.**—The amendments made by this section shall apply with respect to service performed after July 1, 1991.

26 USC 3121
note.

SEC. 11333. EXTENSION OF FUTA SURTAX.

(a) **IN GENERAL.**—Section 3301 (relating to rate of FUTA tax) is amended—

(1) by striking “1988, 1989, and 1990” in paragraph (1) and inserting “1988 through 1995”, and

(2) by striking “1991” in paragraph (2) and inserting “1996”.

(b) **EFFECTIVE DATE.**—The amendments made by this section shall apply to wages paid after December 31, 1990.

26 USC 3301
note.

SEC. 11334. DEPOSITS OF PAYROLL TAXES.

(a) **IN GENERAL.**—⁸⁰ Subsection (g) of section 6302 is amended to read as follows:

“(g) **DEPOSITS OF SOCIAL SECURITY TAXES AND WITHHELD INCOME TAXES.**—If, under regulations prescribed by the Secretary, a person is required to make deposits of taxes imposed by chapters 21 and 24 on the basis of eighth-month periods, such person shall make deposits of such taxes on the 1st banking day after any day on which such person has \$100,000 or more of such taxes for deposit.”

(b) **TECHNICAL AMENDMENT.**—Paragraph (2) of section 7632(b) of the Revenue Reconciliation Act of 1989 is hereby repealed.

(c) **EFFECTIVE DATE.**—The amendments made by this section shall apply to amounts required to be deposited after December 31, 1990.

26 USC 6302
note.
26 USC 6302
note.

PART V—MISCELLANEOUS PROVISIONS

SEC. 11341. INCREASE IN RATE OF INTEREST PAYABLE ON LARGE CORPORATE UNDERPAYMENTS.

(a) **GENERAL RULE.**—Section 6621 (relating to determination of rate of interest) is amended by adding at the end thereof the following new subsection:

“(c) **INCREASE IN UNDERPAYMENT RATE FOR LARGE CORPORATE UNDERPAYMENTS.**—

⁸⁰ So in original. Probably should be “GENERAL.—”.

(e) ELIMINATION OF UNNECESSARY SECTION RELATING TO JURY DUTY PAY REMITTED TO EMPLOYER.—

(1) Paragraph (13) of section 62(a) is amended to read as follows:

“(13) JURY DUTY PAY REMITTED TO EMPLOYER.—Any deduction allowable under this chapter by reason of an individual remitting any portion of any jury pay to such individual’s employer in exchange for payment by the employer of compensation for the period such individual was performing jury duty. For purposes of the preceding sentence, the term ‘jury pay’ means any payment received by the individual for the discharge of jury duty.”

(2) Part VII of subchapter B of chapter 1 is amended by striking out section 220 and redesignating section 221 as section 220.

(3) The table of sections for part VII of subchapter B of chapter 1 is amended by striking the items relating to sections 220 and 221 and inserting in lieu thereof the following:

“Sec. 220. Cross reference.”

(f) OTHER PROVISIONS.—

(1) Section 541 is amended by striking “(38.5 percent in the case of taxable years beginning in 1987)”.

(2) Subsection (e) of section 665 is amended to read as follows:

“(e) PRECEDING TAXABLE YEAR.—For purposes of this subpart—

“(1) In the case of a foreign trust created by a United States person, the term ‘preceding taxable year’ does not include any taxable year of the trust to which this part does not apply.

“(2) In the case of a preceding taxable year with respect to which a trust qualified, without regard to this subpart, under the provisions of subpart B, for purposes of the application of this subpart to such trust for such taxable year, such trust shall, in accordance with regulations prescribed by the Secretary, be treated as a trust to which subpart C applies.”

(3) Subsection (c) of section 668 is amended to read as follows:

“(c) INTEREST CHARGE NOT DEDUCTIBLE.—The interest charge determined under this section shall not be allowed as a deduction for purposes of any tax imposed by this title.”

(4) Paragraph (1) of section 1503(c) is amended by striking the last 2 sentences thereof.

(5) Paragraph (2) of section 2032A(a) is amended to read as follows:

“(2) LIMITATION ON AGGREGATE REDUCTION IN FAIR MARKET VALUE.—The aggregate decrease in the value of qualified real property taken into account for purposes of this chapter which results from the application of paragraph (1) with respect to any decedent shall not exceed \$750,000.”

Subpart B—Modifications to Specific Provisions**SEC. 11811. ELIMINATION OF EXPIRED PROVISIONS IN SECTION 172.**

(a) GENERAL RULE.—Subsection (b) of section 172 is amended to read as follows:

“(b) NET OPERATING LOSS CARRYBACKS AND CARRYOVERS.—

“(1) YEARS TO WHICH LOSS MAY BE CARRIED.—

“(A) GENERAL RULE.—Except as otherwise provided in this paragraph, a net operating loss for any taxable year—

“(i) shall be a net operating loss carryback to each of the 3 taxable years preceding the taxable year of such loss, and

“(ii) shall be a net operating loss carryover to each of the 15 taxable years following the taxable year of the loss.

“(B) SPECIAL RULES FOR REIT’S.—

“(i) IN GENERAL.—A net operating loss for a REIT year shall not be a net operating loss carryback to any taxable year preceding the taxable year of such loss.

“(ii) SPECIAL RULE.—In the case of any net operating loss for a taxable year which is not a REIT year, such loss shall not be carried back to any taxable year which is a REIT year.

“(iii) REIT YEAR.—For purposes of this subparagraph, the term ‘REIT year’ means any taxable year for which the provisions of part II of subchapter M (relating to real estate investment trusts) apply to the taxpayer.

“(C) SPECIFIED LIABILITY LOSSES.—In the case of a taxpayer which has a specified liability loss (as defined in subsection (f)) for a taxable year, such specified liability loss shall be a net operating loss carryback to each of the 10 taxable years preceding the taxable year of such loss.

“(D) BAD DEBT LOSSES OF COMMERCIAL BANKS.—In the case of any bank (as defined in section 585(a)(2)), the portion of the net operating loss for any taxable year beginning after December 31, 1986, and before January 1, 1994, which is attributable to the deduction allowed under section 166(a) shall be a net operating loss carryback to each of the 10 taxable years preceding the taxable year of the loss and a net operating loss carryover to each of the 5 taxable years following the taxable year of such loss.

“(E) EXCESS INTEREST LOSS.—

“(i) IN GENERAL.—If—

“(I) there is a corporate equity reduction transaction, and

“(II) an applicable corporation has a corporate equity reduction interest loss for any loss limitation year ending after August 2, 1989,

then the corporate equity reduction interest loss shall be a net operating loss carryback and carryover to the taxable years described in subparagraph (A), except that such loss shall not be carried back to a taxable year preceding the taxable year in which the corporate equity reduction transaction occurs.

“(ii) LOSS LIMITATION YEAR.—For purposes of clause (i) and subsection (m), the term ‘loss limitation year’ means, with respect to any corporate equity reduction transaction, the taxable year in which such transaction occurs and each of the 2 succeeding taxable years.

“(iii) APPLICABLE CORPORATION.—For purposes of clause (i), the term ‘applicable corporation’ means—

“(I) a C corporation which acquires stock, or the stock of which is acquired in a major stock acquisition,

“(II) a C corporation making distributions with respect to, or redeeming, its stock in connection with an excess distribution, or

“(III) a C corporation which is a successor of a corporation described in subclause (I) or (II).

“(iv) OTHER DEFINITIONS.—

“For definitions of terms used in this subparagraph, see subsection (h).

“(2) AMOUNT OF CARRYBACKS AND CARRYOVERS.—The entire amount of the net operating loss for any taxable year (hereinafter in this section referred to as the ‘loss year’) shall be carried to the earliest of the taxable years to which (by reason of paragraph (1)) such loss may be carried. The portion of such loss which shall be carried to each of the other taxable years shall be the excess, if any, of the amount of such loss over the sum of the taxable income for each of the prior taxable years to which such loss may be carried. For purposes of the preceding sentence, the taxable income for any such prior taxable year shall be computed—

“(A) with the modifications specified in subsection (d) other than paragraphs (1), (4), and (5) thereof, and

“(B) by determining the amount of the net operating loss deduction without regard to the net operating loss for the loss year or for any taxable year thereafter, and the taxable income so computed shall not be considered to be less than zero.

“(3) ELECTION TO WAIVE CARRYBACK.—Any taxpayer entitled to a carryback period under paragraph (1) may elect to relinquish the entire carryback period with respect to a net operating loss for any taxable year. Such election shall be made in such manner as may be prescribed by the Secretary, and shall be made by the due date (including extensions of time) for filing the taxpayer’s return for the taxable year of the net operating loss for which the election is to be in effect. Such election, once made for any taxable year, shall be irrevocable for such taxable year.”

(b) CONFORMING AMENDMENTS.—

(1) Section 172 is amended by striking subsections (g), (h), (i), and (k), and by redesignating subsections (j), (l), (m), and (n) as subsections (f), (g), (h), and (i), respectively.

(2)(A) Subsection (f) of section 172 (as redesignated by paragraph (1)) is amended to read as follows:

“(f) RULES RELATING TO SPECIFIED LIABILITY LOSS.—For purposes of this section—

“(1) IN GENERAL.—The term ‘specified liability loss’ means the sum of the following amounts to the extent taken into account in computing the net operating loss for the taxable year:

“(A) Any amount allowable as a deduction under section 162 or 165 which is attributable to—

“(i) product liability, or

“(ii) expenses incurred in the investigation or settlement of, or opposition to, claims against the taxpayer on account of product liability.

“(B) Any amount (not described in subparagraph (A)) allowable as a deduction under this chapter with respect to a liability which arises under a Federal or State law or out of any tort of the taxpayer if—

“(i) in the case of a liability arising out of a Federal or State law, the act (or failure to act) giving rise to such liability occurs at least 3 years before the beginning of the taxable year, or

“(ii) in the case of a liability arising out of a tort, such liability arises out of a series of actions (or failures to act) over an extended period of time a substantial portion of which occurs at least 3 years before the beginning of the taxable year.

A liability shall not be taken into account under subparagraph (B) unless the taxpayer used an accrual method of accounting throughout the period or periods during which the acts or failures to act giving rise to such liability occurred.

“(2) LIMITATION.—The amount of the specified liability loss for any taxable year shall not exceed the amount of the net operating loss for such taxable year.

“(3) SPECIAL RULE FOR NUCLEAR POWERPLANTS.—Except as provided in regulations prescribed by the Secretary, that portion of a specified liability loss which is attributable to amounts incurred in the decommissioning of a nuclear powerplant (or any unit thereof) may, for purposes of subsection (b)(1)(C), be carried back to each of the taxable years during the period—

“(A) beginning with the taxable year in which such plant (or unit thereof) was placed in service, and

“(B) ending with the taxable year preceding the loss year.

“(4) PRODUCT LIABILITY.—The term ‘product liability’ means—

“(A) liability of the taxpayer for damages on account of physical injury or emotional harm to individuals, or damage to or loss of the use of property, on account of any defect in any product which is manufactured, leased, or sold by the taxpayer, but only if

“(B) such injury, harm, or damage arises after the taxpayer has completed or terminated operations with respect to, and has relinquished possession of, such product.

“(5) COORDINATION WITH SUBSECTION (b) (2).—For purposes of applying subsection (b)(2), a specified liability loss for any taxable year shall be treated as a separate net operating loss for such taxable year to be taken into account after the remaining portion of the net operating loss for such taxable year.

“(6) ELECTION.—Any taxpayer entitled to a 10-year carryback under subsection (b)(1)(C) from any loss year may elect to have the carryback period with respect to such loss year determined without regard to subsection (b)(1)(C). Such election shall be made in such manner as may be prescribed by the Secretary and shall be made by the due date (including extensions of time) for filing the taxpayer’s return for the taxable year of the net operating loss. Such election, once made for any taxable year, shall be irrevocable for that taxable year.”

(B) The portion of any loss which is attributable to a deferred statutory or tort liability loss (as defined in section 172(k) of the Internal Revenue Code of 1986 as in effect on the day before the date of the enactment of this Act) may not be carried back to any taxable year beginning before January 1, 1984, by reason of the amendment made by subparagraph (A).

(3) Paragraph (2) of section 172(g) (as redesignated by paragraph (1)) is amended to read as follows:

26 USC 172 note.

“(2) COORDINATION WITH SUBSECTION (b)(2).—For purposes of subsection (b)(2), the portion of a net operating loss for any taxable year which is attributable to the deduction allowed under section 166(a) shall be treated in a manner similar to the manner in which a specified liability loss is treated.”

(4) Subparagraph (B) of section 172(h)(4) (as redesignated by paragraph (1)) is amended to read as follows:

“(B) COORDINATION WITH SUBSECTION (b)(2).—For purposes of subsection (b)(2)

“(i) a corporate equity reduction interest loss shall be treated in a manner similar to the manner in which a specified liability loss is treated, and

“(ii) in determining the net operating loss deduction for any prior taxable year referred to in the 3rd sentence of subsection (b)(2), the portion of any net operating loss which may not be carried to such taxable year under subsection (b)(1)(E) shall not be taken into account.”

26 USC 172 note.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to net operating losses for taxable years beginning after December 31, 1990.

SEC. 11812. ELIMINATION OF OBSOLETE PROVISIONS IN SECTION 167.

(a) GENERAL RULE.—Section 167 is amended—

(1) by striking subsections (b), (c), (d), (e), (f), (j), (k), (l), (m), (p), and (q) and by redesignating subsections (g), (h), (r), and (s) as subsections (c), (d), (e), and (f), respectively, and

(2) by inserting after subsection (a) the following new subsection:

“(b) CROSS REFERENCE.—

“For determination of depreciation deduction in case of property to which section 168 applies, see section 168.”

(b) CONFORMING AMENDMENTS.—

(1) Subsection (e) of section 167 (as redesignated by subsection (a)) is amended by striking “(h)” each place it appears in paragraphs (3)(B) and (4)(B) and inserting “(d)”.

(2)(A) Subparagraph (A) of section 168(e)(2) is amended to read as follows:

“(A) RESIDENTIAL RENTAL PROPERTY.—

“(i) RESIDENTIAL RENTAL PROPERTY.—The term ‘residential rental property’ means any building or structure if 80 percent or more of the gross rental income from such building or structure for the taxable year is rental income from dwelling units.

“(ii) DEFINITIONS.—For purposes of clause (i)—

“(I) the term ‘dwelling unit’ means a house or apartment used to provide living accommodations in a building or structure, but does not include a unit in a hotel, motel, or other establishment more than one-half of the units in which are used on a transient basis, and

“(II) if any portion of the building or structure is occupied by the taxpayer, the gross rental income from such building or structure shall include the rental value of the portion so occupied.”

TITLE XIII—BUDGET ENFORCEMENT

Subtitle A—Amendments to the Balanced Budget and Emergency Deficit Control Act of 1985 and Related Amendments

Sec. 13001. Short title; table of contents.

PART I—AMENDMENTS TO THE BALANCED BUDGET AND EMERGENCY DEFICIT CONTROL ACT OF 1985

Sec. 13101. Sequestration.

PART II—RELATED AMENDMENTS

Sec. 13111. Temporary amendments to the Congressional Budget Act of 1974.

Sec. 13112. Conforming amendments.

Subtitle B—Permanent Amendments to the Congressional Budget and Impoundment Control Act of 1974

Sec. 13201. Credit accounting.

Sec. 13202. Codification of provision regarding revenue estimates.

Sec. 13203. Debt increase as measure of deficit; display of Federal Retirement Trust Fund balances.

Sec. 13204. Pay-as-you-go procedures.

Sec. 13205. Amendments to section 303.

Sec. 13206. Amendments to section 308.

Sec. 13207. Standardization of language regarding points of order.

Sec. 13208. Standardization of additional deficit control provisions.

Sec. 13209. Codification of precedent with regard to conference reports and amendments between Houses.

Sec. 13210. Superseded deadlines and conforming changes.

Sec. 13211. Definitions.

Sec. 13212. Savings transfers between fiscal years.

Sec. 13213. Conforming change to title 31.

Sec. 13214. The Byrd Rule on extraneous matter in reconciliation.

Subtitle C—Social Security

Sec. 13301. Off-budget status of OASDI trust funds.

Sec. 13302. Protection of OASDI trust funds in the House of Representatives.

Sec. 13303. Social Security firewall and point of order in the Senate.

Sec. 13304. Report to the Congress by the Board of Trustees of the OASDI trust funds regarding the actuarial balance of the trust funds.

Sec. 13305. Exercise of rulemaking power.

Sec. 13306. Effective date.

Subtitle D—Treatment of Fiscal Year 1991 Sequestration

Sec. 13401. Restoration of funds sequestered.

Subtitle E—Government-Sponsored Enterprises

Sec. 13501. Financial safety and soundness of Government-sponsored enterprises.

Subtitle A—Amendments to the Balanced Budget and Emergency Deficit Control Act of 1985 and Related Amendments

PART I—AMENDMENTS TO THE BALANCED BUDGET AND EMERGENCY DEFICIT CONTROL ACT OF 1985

SEC. 13101. SEQUESTRATION.

(a) SECTIONS 250 THROUGH 254.—Sections 251 (except for subsection (a)(6)(I)) through 254 of part C of the Balanced Budget and Emergency Deficit Control Act of 1985 (2 U.S.C. 901 et seq.) are amended to read as follows:

“SEC. 250. TABLE OF CONTENTS; STATEMENT OF BUDGET ENFORCEMENT THROUGH SEQUESTRATION; DEFINITIONS. 2 USC 900.

“(a) TABLE OF CONTENTS.—

“Sec. 250. Table of contents; budget enforcement statement; definitions.

“Sec. 251. Enforcing discretionary spending limits.

“Sec. 252. Enforcing pay-as-you-go.

“Sec. 253. Enforcing deficit targets.

“Sec. 254. Reports and orders.

“Sec. 255. Exempt programs and activities.

“Sec. 256. Special rules.

“Sec. 257. The baseline.

“Sec. 258. Suspension in the event of war or low growth.

“Sec. 258A. Modification of presidential order.

“Sec. 258B. Alternative defense sequestration.

“Sec. 258C. Special reconciliation process.

“(b) GENERAL STATEMENT OF BUDGET ENFORCEMENT THROUGH SEQUESTRATION.—This part provides for the enforcement of the deficit reduction assumed in House Concurrent Resolution 310 (101st Congress, second session) and the applicable deficit targets for fiscal years 1991 through 1995. Enforcement, as necessary, is to be implemented through sequestration—

“(1) to enforce discretionary spending levels assumed in that resolution (with adjustments as provided hereinafter);

“(2) to enforce the requirement that any legislation increasing direct spending or decreasing revenues be on a pay-as-you-go basis; and

“(3) to enforce the deficit targets specifically set forth in the Congressional Budget and Impoundment Control Act of 1974 (with adjustments as provided hereinafter);

applied in the order set forth above.

“(c) DEFINITIONS.—

“As used in this part:

“(1) The terms ‘budget authority’, ‘new budget authority’, ‘outlays’, and ‘deficit’ have the meanings given to such terms in section 3 of the Congressional Budget and Impoundment Control Act of 1974 (but including the treatment specified in section 257(b)(3) of the Hospital Insurance Trust Fund) and the terms ‘maximum deficit amount’ and ‘discretionary spending limit’ shall mean the amounts specified in section 601 of that Act as adjusted under sections 251 and 253 of this Act.

“(2) The terms ‘sequester’ and ‘sequestration’ refer to or mean the cancellation of budgetary resources provided by discretionary appropriations or direct spending law.

“(3) The term ‘breach’ means, for any fiscal year, the amount (if any) by which new budget authority or outlays for that year (within a category of discretionary appropriations) is above that category’s discretionary spending limit for new budget authority or outlays for that year, as the case may be.

“(4) The term ‘category’ means:

“(A) For fiscal years 1991, 1992, and 1993, any of the following subsets of discretionary appropriations: defense, international, or domestic. Discretionary appropriations in each of the three categories shall be those so designated in the joint statement of managers accompanying the conference report on the Omnibus Budget Reconciliation Act of 1990. New accounts or activities shall be categorized in consultation with the Committees on Appropriations and the Budget of the House of Representatives and the Senate.

“(B) For fiscal years 1994 and 1995, all discretionary appropriations.

Contributions to the United States to offset the cost of Operation Desert Shield shall not be counted within any category.

“(5) The term ‘baseline’ means the projection (described in section 257) of current-year levels of new budget authority, outlays, receipts, and the surplus or deficit into the budget year and the outyears.

“(6) The term ‘budgetary resources’ means—

“(A) with respect to budget year 1991, new budget authority; unobligated balances; new loan guarantee commitments or limitations; new direct loan obligations, commitments, or limitations; direct spending authority; and obligation limitations; or

“(B) with respect to budget year 1992, 1993, 1994, or 1995, new budget authority; unobligated balances; direct spending authority; and obligation limitations.

“(7) The term ‘discretionary appropriations’ means budgetary resources (except to fund direct-spending programs) provided in appropriation Acts.

“(8) The term ‘direct spending’ means—

“(A) budget authority provided by law other than appropriation Acts;

“(B) entitlement authority; and

“(C) the food stamp program.

“(9) The term ‘current’ means, with respect to OMB estimates included with a budget submission under section 1105(a) of title 31, United States Code, the estimates consistent with the economic and technical assumptions underlying that budget and with respect to estimates made after submission of the fiscal year 1992 budget that are not included with a budget submission, estimates consistent with the economic and technical assumptions underlying the most recently submitted President’s budget.

“(10) The term ‘real economic growth’, with respect to any fiscal year, means the growth in the gross national product during such fiscal year, adjusted for inflation, consistent with Department of Commerce definitions.

“(11) The term ‘account’ means an item for which appropriations are made in any appropriation Act and, for items not provided for in appropriation Acts, such term means an item for which there is a designated budget account identification code number in the President’s budget.

“(12) The term ‘budget year’ means, with respect to a session of Congress, the fiscal year of the Government that starts on October 1 of the calendar year in which that session begins.

“(13) The term ‘current year’ means, with respect to a budget year, the fiscal year that immediately precedes that budget year.

“(14) The term ‘outyear’ means, with respect to a budget year, any of the fiscal years that follow the budget year through fiscal year 1995.

“(15) The term ‘OMB’ means the Director of the Office of Management and Budget.

“(16) The term ‘CBO’ means the Director of the Congressional Budget Office.

“(17) For purposes of sections 252 and 253, legislation enacted during the second session of the One Hundred First Congress shall be deemed to have been enacted before the enactment of this Act.

“(18) As used in this part, all references to entitlement authority shall include the list of mandatory appropriations included in the joint explanatory statement of managers accompanying the conference report on the Omnibus Budget Reconciliation Act of 1990.

“(19) The term ‘deposit insurance’ refers to the expenses of the Federal Deposit Insurance Corporation and the funds it incorporates, the Resolution Trust Corporation, the National Credit Union Administration and the funds it incorporates, the Office of Thrift Supervision, the Comptroller of the Currency Assessment Fund, and the RTC Office of Inspector General.

“(20) The term ‘composite outlay rate’ means the percent of new budget authority that is converted to outlays in the fiscal year for which the budget authority is provided and subsequent fiscal years, as follows:

“(A) For the international category, 46 percent for the first year, 20 percent for the second year, 16 percent for the third year, and 8 percent for the fourth year.

“(B) For the domestic category, 53 percent for the first year, 31 percent for the second year, 12 percent for the third year, and 2 percent for the fourth year.

“SEC. 251. ENFORCING DISCRETIONARY SPENDING LIMITS.

2 USC 901.

“(a) FISCAL YEARS 1991-1995 ENFORCEMENT.—

“(1) SEQUESTRATION.—Within 15 calendar days after Congress adjourns to end a session and on the same day as a sequestration (if any) under section 252 and section 253, there shall be a sequestration to eliminate a budget-year breach, if any, within any category.

“(2) ELIMINATING A BREACH.—Each non-exempt account within a category shall be reduced by a dollar amount calculated by multiplying the baseline level of sequestrable budgetary resources in that account at that time by the uniform percentage necessary to eliminate a breach within that category; except that the health programs set forth in section 256(e) shall not be reduced by more than 2 percent and the uniform percent applicable to all other programs under this paragraph shall be increased (if necessary) to a level sufficient to eliminate that breach. If, within a category, the discretionary spending limits for both new budget authority and outlays are breached, the uniform percentage shall be calculated by—

“(A) first, calculating the uniform percentage necessary to eliminate the breach in new budget authority, and

“(B) second, if any breach in outlays remains, increasing the uniform percentage to a level sufficient to eliminate that breach.

“(3) MILITARY PERSONNEL.—If the President uses the authority to exempt any military personnel from sequestration under section 255(h), each account within subfunctional category 051 (other than those military personnel accounts for which the authority provided under section 255(h) has been exercised) shall be further reduced by a dollar amount calculated by multiplying the enacted level of non-exempt budgetary re-

sources in that account at that time by the uniform percentage necessary to offset the total dollar amount by which outlays are not reduced in military personnel accounts by reason of the use of such authority.

“(4) **PART-YEAR APPROPRIATIONS.**—If, on the date specified in paragraph (1), there is in effect an Act making or continuing appropriations for part of a fiscal year for any budget account, then the dollar sequestration calculated for that account under paragraphs (2) and (3) shall be subtracted from—

“(A) the annualized amount otherwise available by law in that account under that or a subsequent part-year appropriation; and

“(B) when a full-year appropriation for that account is enacted, from the amount otherwise provided by the full-year appropriation.

“(5) **LOOK-BACK.**—If, after June 30, an appropriation for the fiscal year in progress is enacted that causes a breach within a category for that year (after taking into account any sequestration of amounts within that category), the discretionary spending limits for that category for the next fiscal year shall be reduced by the amount or amounts of that breach.

“(6) **WITHIN-SESSION SEQUESTRATION.**—If an appropriation for a fiscal year in progress is enacted (after Congress adjourns to end the session for that budget year and before July 1 of that fiscal year) that causes a breach within a category for that year (after taking into account any prior sequestration of amounts within that category), 15 days later there shall be a sequestration to eliminate that breach within that category following the procedures set forth in paragraphs (2) through (4).

“(7) **OMB ESTIMATES.**—As soon as practicable after Congress completes action on any discretionary appropriation, CBO, after consultation with the Committees on the Budget of the House of Representatives and the Senate, shall provide OMB with an estimate of the amount of discretionary new budget authority and outlays for the current year (if any) and the budget year provided by that legislation. Within 5 calendar days after the enactment of any discretionary appropriation, OMB shall transmit a report to the House of Representatives and to the Senate containing the CBO estimate of that legislation, an OMB estimate of the amount of discretionary new budget authority and outlays for the current year (if any) and the budget year provided by that legislation, and an explanation of any difference between the two estimates. For purposes of this paragraph, amounts provided by annual appropriations shall include any new budget authority and outlays for those years in accounts for which funding is provided in that legislation that result from previously enacted legislation. Those OMB estimates shall be made using current economic and technical assumptions. OMB shall use the OMB estimates transmitted to the Congress under this paragraph for the purposes of this subsection. OMB and CBO shall prepare estimates under this paragraph in conformance with scorekeeping guidelines determined after consultation among the House and Senate Committees on the Budget, CBO, and OMB.

“(b) **ADJUSTMENTS TO DISCRETIONARY SPENDING LIMITS.**—(1) When the President submits the budget under section 1105(a) of title 31, United States Code, for budget year 1992, 1993, 1994, or 1995 (except

as otherwise indicated), OMB shall calculate (in the order set forth below), and the budget shall include, adjustments to discretionary spending limits (and those limits as cumulatively adjusted) for the budget year and each outyear through 1995 to reflect the following:

“(A) **CHANGES IN CONCEPTS AND DEFINITIONS.**—The adjustments produced by the amendments made by title XIII of the Omnibus Budget Reconciliation Act of 1990 or by any other changes in concepts and definitions shall equal the baseline levels of new budget authority and outlays using up-to-date concepts and definitions minus those levels using the concepts and definitions in effect before such changes. Such other changes in concepts and definitions may only be made in consultation with the Committees on Appropriations, the Budget, Government Operations, and Governmental Affairs of the House of Representatives and Senate.

“(B) **CHANGES IN INFLATION.**—(i) For a budget submitted for budget year 1992, 1993, 1994, or 1995, the adjustments produced by changes in inflation shall equal the levels of discretionary new budget authority and outlays in the baseline (calculated using current estimates) subtracted from those levels in that baseline recalculated with the baseline inflators for the budget year only, multiplied by the inflation adjustment factor computed under clause (ii).

“(ii) For a budget year the inflation adjustment factor shall equal the ratio between the level of year-over-year inflation measured for the fiscal year most recently completed and the applicable estimated level for that year set forth below:

“For 1990, 1.041

“For 1991, 1.052

“For 1992, 1.041

“For 1993, 1.033

Inflation shall be measured by the average of the estimated gross national product implicit price deflator index for a fiscal year divided by the average index for the prior fiscal year.

“(C) **CREDIT REESTIMATES.**—For a budget submitted for fiscal year 1993 or 1994, the adjustments produced by reestimates to costs of Federal credit programs shall be, for any such program, a current estimate of new budget authority and outlays associated with a baseline projection of the prior year's gross loan level for that program minus the baseline projection of the prior year's new budget authority and associated outlays for that program.

“(2) When OMB submits a sequestration report under section 254(g) or (h) for fiscal year 1991, 1992, 1993, 1994, or 1995 (except as otherwise indicated), OMB shall calculate (in the order set forth below), and the sequestration report, and subsequent budgets submitted by the President under section 1105(a) of title 31, United States Code, shall include, adjustments to discretionary spending limits (and those limits as adjusted) for the fiscal year and each succeeding year through 1995, as follows:

“(A) **IRS FUNDING.**—To the extent that appropriations are enacted that provide additional new budget authority or result in additional outlays (as compared with the CBO baseline constructed in June 1990) for the Internal Revenue Service compliance initiative in any fiscal year, the adjustments for that year shall be those amounts, but shall not exceed the amounts set forth below—

“(i) for fiscal year 1991, \$191,000,000 in new budget authority and \$183,000,000 in outlays;

“(ii) for fiscal year 1992, \$172,000,000 in new budget authority and \$169,000,000 in outlays;

“(iii) for fiscal year 1993, \$183,000,000 in new budget authority and \$179,000,000 in outlays;

“(iv) for fiscal year 1994, \$187,000,000 in new budget authority and \$183,000,000 in outlays; and

“(v) for fiscal year 1995, \$188,000,000 in new budget authority and \$184,000,000 in outlays; and the prior-year outlays resulting from these appropriations of budget authority.

“(B) DEBT FORGIVENESS.—If, in calendar year 1990 or 1991, an appropriation is enacted that forgives the Arab Republic of Egypt's foreign military sales indebtedness to the United States and any part of the Government of Poland's indebtedness to the United States, the adjustment shall be the estimated costs (in new budget authority and outlays, in all years) of that forgiveness.

“(C) IMF FUNDING.—If, in fiscal year 1991, 1992, 1993, 1994, or 1995 an appropriation is enacted to provide to the International Monetary Fund the dollar equivalent, in terms of Special Drawing Rights, of the increase in the United States quota as part of the International Monetary Fund Ninth General Review of Quotas, the adjustment shall be the amount provided by that appropriation.

“(D) EMERGENCY APPROPRIATIONS.—(i) If, for fiscal year 1991, 1992, 1993, 1994, or 1995, appropriations for discretionary accounts are enacted that the President designates as emergency requirements and that the Congress so designates in statute, the adjustment shall be the total of such appropriations in discretionary accounts designated as emergency requirements and the outlays flowing in all years from such appropriations.

“(ii) The costs for operation Desert Shield are to be treated as emergency funding requirements not subject to the defense spending limits. Funding for Desert Shield will be provided through the normal legislative process. Desert Shield costs should be accommodated through Allied burden-sharing, subsequent appropriation Acts, and if the President so chooses, through offsets within other defense accounts. Emergency Desert Shield costs mean those incremental costs associated with the increase in operations in the Middle East and do not include costs that would be experienced by the Department of Defense as part of its normal operations absent Operation Desert Shield.

“(E) SPECIAL ALLOWANCE FOR DISCRETIONARY NEW BUDGET AUTHORITY.—(i) For each of fiscal years 1992 and 1993, the adjustment for the domestic category in each year shall be an amount equal to 0.1 percent of the sum of the adjusted discretionary spending limits on new budget authority for all categories for fiscal years 1991, 1992, and 1993 (cumulatively), together with outlays associated therewith (calculated at the composite outlay rate for the domestic category);

“(ii) for each of fiscal years 1992 and 1993, the adjustment for the international category in each year shall be an amount equal to 0.079 percent of the sum of the adjusted discretionary spending limits on new budget authority for all categories for

fiscal years 1991, 1992, and 1993 (cumulatively), together with outlays associated therewith (calculated at the composite outlay rate for the international category); and

“(iii) if, for fiscal years 1992 and 1993, the amount of new budget authority provided in appropriation Acts exceeds the discretionary spending limit on new budget authority for any category due to technical estimates made by the Director of the Office of Management and Budget, the adjustment is the amount of the excess, but not to exceed an amount (for 1992 and 1993 together) equal to 0.042 percent of the sum of the adjusted discretionary limits on new budget authority for all categories for fiscal years 1991, 1992, and 1993 (cumulatively).

“(F) SPECIAL OUTLAY ALLOWANCE.—If in any fiscal year outlays for a category exceed the discretionary spending limit for that category but new budget authority does not exceed its limit for that category (after application of the first step of a sequestration described in subsection (a)(2), if necessary), the adjustment in outlays is the amount of the excess, but not to exceed \$2,500,000,000 in the defense category, \$1,500,000,000 in the international category, or \$2,500,000,000 in the domestic category (as applicable) in fiscal year 1991, 1992, or 1993, and not to exceed \$6,500,000,000 in fiscal year 1994 or 1995 less any of the outlay adjustments made under subparagraph (E) for a category for a fiscal year.

“SEC. 252. ENFORCING PAY-AS-YOU-GO.

2 USC 902.

“(a) FISCAL YEARS 1992-1995 ENFORCEMENT.—The purpose of this section is to assure that any legislation (enacted after the date of enactment of this section) affecting direct spending or receipts that increases the deficit in any fiscal year covered by this Act will trigger an offsetting sequestration.

“(b) SEQUESTRATION; LOOK-BACK.—Within 15 calendar days after Congress adjourns to end a session (other than of the One Hundred First Congress) and on the same day as a sequestration (if any) under section 251 and section 253, there shall be a sequestration to offset the amount of any net deficit increase in that fiscal year and the prior fiscal year caused by all direct spending and receipts legislation enacted after the date of enactment of this section (after adjusting for any prior sequestration as provided by paragraph (2)). OMB shall calculate the amount of deficit increase, if any, in those fiscal years by adding—

“(1) all applicable estimates of direct spending and receipts legislation transmitted under subsection (d) applicable to those fiscal years, other than any amounts included in such estimates resulting from—

“(A) full funding of, and continuation of, the deposit insurance guarantee commitment in effect on the date of enactment of this section, and

“(B) emergency provisions as designated under subsection (e); and

“(2) the estimated amount of savings in direct spending programs applicable to those fiscal years resulting from the prior year's sequestration under this section or section 253, if any (except for any amounts sequestered as a result of a net deficit increase in the fiscal year immediately preceding the prior fiscal year), as published in OMB's end-of-session sequestration report for that prior year.

“(c) **ELIMINATING A DEFICIT INCREASE.**—(1) The amount required to be sequestered in a fiscal year under subsection (b) shall be obtained from non-exempt direct spending accounts from actions taken in the following order:

“(A) **FIRST.**—All reductions in automatic spending increases specified in section 256(a) shall be made.

“(B) **SECOND.**—If additional reductions in direct spending accounts are required to be made, the maximum reductions permissible under sections 256(b) (guaranteed student loans) and 256(c) (foster care and adoption assistance) shall be made.

“(C) **THIRD.**—(i) If additional reductions in direct spending accounts are required to be made, each remaining non-exempt direct spending account shall be reduced by the uniform percentage necessary to make the reductions in direct spending required by paragraph (1); except that the medicare programs specified in section 256(d) shall not be reduced by more than 4 percent and the uniform percentage applicable to all other direct spending programs under this paragraph shall be increased (if necessary) to a level sufficient to achieve the required reduction in direct spending.

“(ii) For purposes of determining reductions under clause (i), outlay reductions (as a result of sequestration of Commodity Credit Corporation commodity price support contracts in the fiscal year of a sequestration) that would occur in the following fiscal year shall be credited as outlay reductions in the fiscal year of the sequestration.

“(2) For purposes of this subsection, accounts shall be assumed to be at the level in the baseline.

“(d) **OMB ESTIMATES.**—As soon as practicable after Congress completes action on any direct spending or receipts legislation enacted after the date of enactment of this section, after consultation with the Committees on the Budget of the House of Representatives and the Senate, CBO shall provide OMB with an estimate of the amount of change in outlays or receipts, as the case may be, in each fiscal year through fiscal year 1995 resulting from that legislation. Within 5 calendar days after the enactment of any direct spending or receipts legislation enacted after the date of enactment of this section, OMB shall transmit a report to the House of Representatives and to the Senate containing such CBO estimate of that legislation, an OMB estimate of the amount of change in outlays or receipts, as the case may be, in each fiscal year through fiscal year 1995 resulting from that legislation, and an explanation of any difference between the two estimates. Those OMB estimates shall be made using current economic and technical assumptions. OMB and CBO shall prepare estimates under this paragraph in conformance with scorekeeping guidelines determined after consultation among the House and Senate Committees on the Budget, CBO, and OMB.

“(e) **EMERGENCY LEGISLATION.**—If, for fiscal year 1991, 1992, 1993, 1994, or 1995, a provision of direct spending or receipts legislation is enacted that the President designates as an emergency requirement and that the Congress so designates in statute, the amounts of new budget authority, outlays, and receipts in all fiscal years through 1995 resulting from that provision shall be designated as an emergency requirement in the reports required under subsection (d).

“SEC. 253. ENFORCING DEFICIT TARGETS.

2 USC 903.

“(a) SEQUESTRATION.—Within 15 calendar days after Congress adjourns to end a session (other than of the One Hundred First Congress) and on the same day as a sequestration (if any) under section 251 and section 252, but after any sequestration required by section 251 (enforcing discretionary spending limits) or section 252 (enforcing pay-as-you-go), there shall be a sequestration to eliminate the excess deficit (if any remains) if it exceeds the margin.

“(b) EXCESS DEFICIT; MARGIN.—The excess deficit is, if greater than zero, the estimated deficit for the budget year, minus—

“(1) the maximum deficit amount for that year;

“(2) the amounts for that year designated as emergency direct spending or receipts legislation under section 252(e); and

“(3) for any fiscal year in which there is not a full adjustment for technical and economic reestimates, the deposit insurance reestimate for that year, if any, calculated under subsection (h). The ‘margin’ for fiscal year 1992 or 1993 is zero and for fiscal year 1994 or 1995 is \$15,000,000,000.

“(c) DIVIDING THE SEQUESTRATION.—To eliminate the excess deficit in a budget year, half of the required outlay reductions shall be obtained from non-exempt defense accounts (accounts designated as function 050 in the President’s fiscal year 1991 budget submission) and half from non-exempt, non-defense accounts (all other non-exempt accounts).

“(d) DEFENSE.—Each non-exempt defense account shall be reduced by a dollar amount calculated by multiplying the level of sequestrable budgetary resources in that account at that time by the uniform percentage necessary to carry out subsection (c), except that, if any military personnel are exempt, adjustments shall be made under the procedure set forth in section 251(a)(3).

“(e) NON-DEFENSE.—Actions to reduce non-defense accounts shall be taken in the following order:

“(1) FIRST.—All reductions in automatic spending increases under section 256(a) shall be made.

“(2) SECOND.—If additional reductions in non-defense accounts are required to be made, the maximum reduction permissible under sections 256(b) (guaranteed student loans) and 256(c) (foster care and adoption assistance) shall be made.

“(3) THIRD.—(A) If additional reductions in non-defense accounts are required to be made, each remaining non-exempt, non-defense account shall be reduced by the uniform percentage necessary to make the reductions in non-defense outlays required by subsection (c), except that—

“(i) the medicare program specified in section 256(d) shall not be reduced by more than 2 percent in total including any reduction of less than 2 percent made under section 252 or, if it has been reduced by 2 percent or more under section 252, it may not be further reduced under this section; and

“(ii) the health programs set forth in section 256(e) shall not be reduced by more than 2 percent in total (including any reduction made under section 251),

and the uniform percent applicable to all other programs under this subsection shall be increased (if necessary) to a level sufficient to achieve the required reduction in non-defense outlays.

“(B) For purposes of determining reductions under subparagraph (A), outlay reduction (as a result of sequestration of

Commodity Credit Corporation commodity price support contracts in the fiscal year of a sequestration) that would occur in the following fiscal year shall be credited as outlay reductions in the fiscal year of the sequestration.

“(f) BASELINE ASSUMPTIONS; PART-YEAR APPROPRIATIONS.—

“(1) BUDGET ASSUMPTIONS.—For purposes of subsections (b), (c), (d), and (e), accounts shall be assumed to be at the level in the baseline minus any reductions required to be made under sections 251 and 252.

“(2) PART-YEAR APPROPRIATIONS.—If, on the date specified in subsection (a), there is in effect an Act making or continuing appropriations for part of a fiscal year for any non-exempt budget account, then the dollar sequestration calculated for that account under subsection (d) or (e), as applicable, shall be subtracted from—

“(A) the annualized amount otherwise available by law in that account under that or a subsequent part-year appropriation; and

“(B) when a full-year appropriation for that account is enacted, from the amount otherwise provided by the full-year appropriation; except that the amount to be sequestered from that account shall be reduced (but not below zero) by the savings achieved by that appropriation when the enacted amount is less than the baseline for that account.

“(g) ADJUSTMENTS TO MAXIMUM DEFICIT AMOUNTS.—

“(1) ADJUSTMENTS.—

“(A) When the President submits the budget for fiscal year 1992, the maximum deficit amounts for fiscal years 1992, 1993, 1994, and 1995 shall be adjusted to reflect up-to-date reestimates of economic and technical assumptions and any changes in concepts or definitions. When the President submits the budget for fiscal year 1993, the maximum deficit amounts for fiscal years 1993, 1994, and 1995 shall be further adjusted to reflect up-to-date reestimates of economic and technical assumptions and any changes in concepts or definitions.

“(B) When submitting the budget for fiscal year 1994, the President may choose to adjust the maximum deficit amounts for fiscal years 1994 and 1995 to reflect up-to-date reestimates of economic and technical assumptions. If the President chooses to adjust the maximum deficit amount when submitting the fiscal year 1994 budget, the President may choose to invoke the same adjustment procedure when submitting the budget for fiscal year 1995. In each case, the President must choose between making no adjustment or the full adjustment described in paragraph (2). If the President chooses to make that full adjustment, then those procedures for adjusting discretionary spending limits described in sections 251(b)(1)(C) and 251(b)(2)(E), otherwise applicable through fiscal year 1993 or 1994 (as the case may be), shall be deemed to apply for fiscal year 1994 (and 1995 if applicable).

“(C) When the budget for fiscal year 1994 or 1995 is submitted and the sequestration reports for those years under section 254 are made (as applicable), if the President does not choose to make the adjustments set forth in

subparagraph (B), the maximum deficit amount for that fiscal year shall be adjusted by the amount of the adjustment to discretionary spending limits first applicable for that year (if any) under section 251(b).

“(D) For each fiscal year the adjustments required to be made with the submission of the President’s budget for that year shall also be made when OMB submits the sequestration update report and the final sequestration report for that year, but OMB shall continue to use the economic and technical assumptions in the President’s budget for that year.

Each adjustment shall be made by increasing or decreasing the maximum deficit amounts set forth in section 601 of the Congressional Budget Act of 1974.

“(2) CALCULATIONS OF ADJUSTMENTS.—The required increase or decrease shall be calculated as follows:

“(A) The baseline deficit or surplus shall be calculated using up-to-date economic and technical assumptions, using up-to-date concepts and definitions, and, in lieu of the baseline levels of discretionary appropriations, using the discretionary spending limits set forth in section 601 of the Congressional Budget Act of 1974 as adjusted under section 251.

“(B) The net deficit increase or decrease caused by all direct spending and receipts legislation enacted after the date of enactment of this section (after adjusting for any sequestration of direct spending accounts) shall be calculated for each fiscal year by adding—

“(i) the estimates of direct spending and receipts legislation transmitted under section 252(d) applicable to each such fiscal year; and

“(ii) the estimated amount of savings in direct spending programs applicable to each such fiscal year resulting from the prior year’s sequestration under this section or section 252 of direct spending, if any, as contained in OMB’s final sequestration report for that year.

“(C) The amount calculated under subparagraph (B) shall be subtracted from the amount calculated under subparagraph (A).

“(D) The maximum deficit amount set forth in section 601 of the Congressional Budget Act of 1974 shall be subtracted from the amount calculated under subparagraph (C).

“(E) The amount calculated under subparagraph (D) shall be the amount of the adjustment required by paragraph (1).

“(h) TREATMENT OF DEPOSIT INSURANCE.—

“(1) INITIAL ESTIMATES.—The initial estimates of the net costs of federal deposit insurance for fiscal year 1994 and fiscal year 1995 (assuming full funding of, and continuation of, the deposit insurance guarantee commitment in effect on the date of the submission of the budget for fiscal year 1993) shall be set forth in that budget.

“(2) REESTIMATES.—For fiscal year 1994 and fiscal year 1995, the amount of the reestimate of deposit insurance costs shall be calculated by subtracting the amount set forth under paragraph (1) for that year from the current estimate of deposit insurance costs (but assuming full funding of, and continuation of, the

deposit insurance guarantee commitment in effect on the date of submission of the budget for fiscal year 1993).

2 USC 904.

"SEC. 254. REPORTS AND ORDERS.

"(a) TIMETABLE.—The timetable with respect to this part for any budget year is as follows:

"Date:	Action to be completed:
January 21	Notification regarding optional adjustment of maximum deficit amount.
5 days before the President's budget submission.	CBO sequestration preview report.
The President's budget submission	OMB sequestration preview report.
August 10	Notification regarding military personnel.
August 15	CBO sequestration update report.
August 20	OMB sequestration update report.
10 days after end of session	CBO final sequestration report.
15 days after end of session	OMB final sequestration report; Presidential order.
30 days later	GAO compliance report.

"(b) SUBMISSION AND AVAILABILITY OF REPORTS.—Each report required by this section shall be submitted, in the case of CBO, to the House of Representatives, the Senate and OMB and, in the case of OMB, to the House of Representatives, the Senate, and the President on the day it is issued. On the following day a notice of the report shall be printed in the Federal Register.

"(c) OPTIONAL ADJUSTMENT OF MAXIMUM DEFICIT AMOUNTS.—With respect to budget year 1994 or 1995, on the date specified in subsection (a) the President shall notify the House of Representatives and the Senate of his decision regarding the optional adjustment of the maximum deficit amount (as allowed under section 253(g)(1)(B)).

"(d) SEQUESTRATION PREVIEW REPORTS.—

"(1) REPORTING REQUIREMENT.—On the dates specified in subsection (a), OMB and CBO shall issue a preview report regarding discretionary, pay-as-you-go, and deficit sequestration based on laws enacted through those dates.

"(2) DISCRETIONARY SEQUESTRATION REPORT.—The preview reports shall set forth estimates for the current year and each subsequent year through 1995 of the applicable discretionary spending limits for each category and an explanation of any adjustments in such limits under section 251.

"(3) PAY-AS-YOU-GO SEQUESTRATION REPORTS.—The preview reports shall set forth, for the current year and the budget year, estimates for each of the following:

"(A) The amount of net deficit increase or decrease, if any, calculated under subsection 252(b).

"(B) A list identifying each law enacted and sequestration implemented after the date of enactment of this section included in the calculation of the amount of deficit increase or decrease and specifying the budgetary effect of each such law.

"(C) The sequestration percentage or (if the required sequestration percentage is greater than the maximum allowable percentage for medicare) percentages necessary to eliminate a deficit increase under section 252(c).

"(4) DEFICIT SEQUESTRATION REPORTS.—The preview reports shall set forth for the budget year estimates for each of the following:

“(A) The maximum deficit amount, the estimated deficit calculated under section 253(b), the excess deficit, and the margin.

“(B) The amount of reductions required under section 252, the excess deficit remaining after those reductions have been made, and the amount of reductions required from defense accounts and the reductions required from non-defense accounts.

“(C) The sequestration percentage necessary to achieve the required reduction in defense accounts under section 253(d).

“(D) The reductions required under sections 253(e)(1) and 253(e)(2).

“(E) The sequestration percentage necessary to achieve the required reduction in non-defense accounts under section 253(e)(3).

The CBO report need not set forth the items other than the maximum deficit amount for fiscal year 1992, 1993, or any fiscal year for which the President notifies the House of Representatives and the Senate that he will adjust the maximum deficit amount under the option under section 253(g)(1)(B).

“(5) EXPLANATION OF DIFFERENCES.—The OMB reports shall explain the differences between OMB and CBO estimates for each item set forth in this subsection.

“(e) NOTIFICATION REGARDING MILITARY PERSONNEL.—On or before the date specified in subsection (a), the President shall notify the Congress of the manner in which he intends to exercise flexibility with respect to military personnel accounts under section 255(h).

“(f) SEQUESTRATION UPDATE REPORTS.—On the dates specified in subsection (a), OMB and CBO shall issue a sequestration update report, reflecting laws enacted through those dates, containing all of the information required in the sequestration preview reports.

“(g) FINAL SEQUESTRATION REPORTS.—

“(1) REPORTING REQUIREMENT.—On the dates specified in subsection (a), OMB and CBO shall issue a final sequestration report, updated to reflect laws enacted through those dates.

“(2) DISCRETIONARY SEQUESTRATION REPORTS.—The final reports shall set forth estimates for each of the following:

“(A) For the current year and each subsequent year through 1995 the applicable discretionary spending limits for each category and an explanation of any adjustments in such limits under section 251.

“(B) For the current year and the budget year the estimated new budget authority and outlays for each category and the breach, if any, in each category.

“(C) For each category for which a sequestration is required, the sequestration percentages necessary to achieve the required reduction.

“(D) For the budget year, for each account to be sequestered, estimates of the baseline level of sequestrable budgetary resources and resulting outlays and the amount of budgetary resources to be sequestered and resulting outlay reductions.

“(3) PAY-AS-YOU-GO AND DEFICIT SEQUESTRATION REPORTS.—The final reports shall contain all the information required in the pay-as-you-go and deficit sequestration preview reports. In addition, these reports shall contain, for the budget year, for each

account to be sequestered, estimates of the baseline level of sequestrable budgetary resources and resulting outlays and the amount of budgetary resources to be sequestered and resulting outlay reductions. The reports shall also contain estimates of the effects on outlays of the sequestration in each outyear through 1995 for direct spending programs.

“(4) EXPLANATION OF DIFFERENCES.—The OMB report shall explain any differences between OMB and CBO estimates of the amount of any net deficit change calculated under subsection 252(b), any excess deficit, any breach, and any required sequestration percentage. The OMB report shall also explain differences in the amount of sequesterable resources for any budget account to be reduced if such difference is greater than \$5,000,000.

“(5) PRESIDENTIAL ORDER.—On the date specified in subsection (a), if in its final sequestration report OMB estimates that any sequestration is required, the President shall issue an order fully implementing without change all sequestrations required by the OMB calculations set forth in that report. This order shall be effective on issuance.

“(h) WITHIN-SESSION SEQUESTRATION REPORTS AND ORDER.—If an appropriation for a fiscal year in progress is enacted (after Congress adjourns to end the session for that budget year and before July 1 of that fiscal year) that causes a breach, 10 days later CBO shall issue a report containing the information required in paragraph (g)(2). Fifteen days after enactment, OMB shall issue a report containing the information required in paragraphs (g)(2) and (g)(4). On the same day as the OMB report, the President shall issue an order fully implementing without change all sequestrations required by the OMB calculations set forth in that report. This order shall be effective on issuance.

“(i) GAO COMPLIANCE REPORT.—On the date specified in subsection (a), the Comptroller General shall submit to the Congress and the President a report on—

“(1) the extent to which each order issued by the President under this section complies with all of the requirements contained in this part, either certifying that the order fully and accurately complies with such requirements or indicating the respects in which it does not; and

“(2) the extent to which each report issued by OMB or CBO under this section complies with all of the requirements contained in this part, either certifying that the report fully and accurately complies with such requirements or indicating the respects in which it does not.

“(j) LOW-GROWTH REPORT.—At any time, CBO shall notify the Congress if—

“(1) during the period consisting of the quarter during which such notification is given, the quarter preceding such notification, and the 4 quarters following such notification, CBO or OMB has determined that real economic growth is projected or estimated to be less than zero with respect to each of any 2 consecutive quarters within such period; or

“(2) the most recent of the Department of Commerce’s advance preliminary or final reports of actual real economic growth indicate that the rate of real economic growth for each of the most recently reported quarter and the immediately preceding quarter is less than one percent.

“(k) **ECONOMIC AND TECHNICAL ASSUMPTIONS.**—In all reports required by this section, OMB shall use the same economic and technical assumptions as used in the most recent budget submitted by the President under section 1105(a) of title 31, United States Code.”.

(b) **SECTION 250: DEFINITIONS.**—Paragraph (12) of section 257 of such Act (as in effect immediately before the date of enactment of this Act) is redesignated as a new paragraph (21) of section 250(c). 2 USC 900, 907.

(c) **SECTION 255: EXEMPT PROGRAMS AND ACTIVITIES.**—

(1) Section 255(a) of such Act is amended to read as follows: 2 USC 905.

“(a) **SOCIAL SECURITY BENEFITS AND TIER I RAILROAD RETIREMENT BENEFITS.**—Benefits payable under the old-age, survivors, and disability insurance program established under title II of the Social Security Act, and benefits payable under section 3(a), 3(f)(3), 4(a), or 4(f) of the Railroad Retirement Act of 1974, shall be exempt from reduction under any order issued under this part.”.

(2) Section 255(e) of such Act is amended to read as follows:

“(e) **NON-DEFENSE UNOBLIGATED BALANCES.**—Unobligated balances of budget authority carried over from prior fiscal years, except balances in the defense category, shall be exempt from reduction under any order issued under this part.”.

(3) Section 255(g)(1)(B) of such Act is amended by inserting after the item relating to Railroad retirement tier II the following:

“Railroad supplemental annuity pension fund (60-8012-0-7-602);”.

(4) Section 255 of such Act is amended by inserting at the end the following:

“(h) **OPTIONAL EXEMPTION OF MILITARY PERSONNEL.**—

“(1) The President may, with respect to any military personnel account, exempt that account from sequestration or provide for a lower uniform percentage reduction than would otherwise apply.

“(2) The President may not use the authority provided by paragraph (1) unless he notifies the Congress of the manner in which such authority will be exercised on or before the initial snapshot date for the budget year.”.

(d) **SECTION 256: EXCEPTIONS, LIMITATIONS, AND SPECIAL RULES.**—

(1) Section 256(a) of such Act is amended to read as follows: 2 USC 906.

“(a) **AUTOMATIC SPENDING INCREASES.**—Automatic spending increases are increases in outlays due to changes in indexes in the following programs:

“(1) National Wool Act;

“(2) Special milk program; and

“(3) Vocational rehabilitation basic State grants.

In those programs all amounts other than the automatic spending increases shall be exempt from reduction under any order issued under this part.”.

(2) Section 256 of such Act is amended by redesignating subsection (b) as subsection (h), subsection (c) as subsection (b), subsection (e) as subsection (f), subsection (f) as subsection (c), subsection (h) as subsection (i), and subsection (k) as subsection (e), by repealing subsections (i) and (l), and by inserting at the end the following:

“(k) **SPECIAL RULES FOR THE JOBS PORTION OF AFDC.**—

“(1) **FULL AMOUNT OF SEQUESTRATION REQUIRED.**—Any order issued by the President under section 254 shall accomplish the

full amount of any required sequestration of the job opportunities and basic skills training program under section 402(a)(19), and part F of title VI, of the Social Security Act, in the manner specified in this subsection. Such an order may not reduce any Federal matching rate pursuant to section 403(l) of the Social Security Act.

“(2) NEW ALLOTMENT FORMULA.—

“(A) GENERAL RULE.—Notwithstanding section 403(k) of the Social Security Act, each State’s percentage share of the amount available after sequestration for direct spending pursuant to section 403(l) of such Act for the fiscal year to which the sequestration applies shall be equal to—

“(i) the lesser of—

“(I) that percentage of the total amount paid to the States pursuant to such section 403(l) for the prior fiscal year that is represented by the amount paid to such State pursuant to such section 403(l) for the prior fiscal year; or

“(II) the amount that would have been allotted to such State pursuant to such section 403(k) had the sequestration not been in effect.

“(B) REALLOTMENT OF AMOUNTS REMAINING UNALLOTTED AFTER APPLICATION OF GENERAL RULE.—Any amount made available after sequestration for direct spending pursuant to section 403(l) of the Social Security Act for the fiscal year to which the sequestration applies that remains unallotted as a result of subparagraph (A) of this paragraph shall be allotted among the States in proportion to the absolute difference between the amount allotted, respectively, to each State as a result of such subparagraph and the amount that would have been allotted to such State pursuant to section 403(k) of such Act had the sequestration not been in effect, except that a State may not be allotted an amount under this subparagraph that results in a total allotment to the State under this paragraph of more than the amount that would have been allotted to such State pursuant to such section 403(k) had the sequestration not been in effect.

“(1) EFFECTS OF SEQUESTRATION.—The effects of sequestration shall be as follows:

“(1) Budgetary resources sequestered from any account other than a trust or special fund account shall be permanently cancelled.

“(2) Except as otherwise provided, the same percentage sequestration shall apply to all programs, projects, and activities within a budget account (with programs, projects, and activities as delineated in the appropriation Act or accompanying report for the relevant fiscal year covering that account, or for accounts not included in appropriation Acts, as delineated in the most recently submitted President’s budget).

“(3) Administrative regulations or similar actions implementing a sequestration shall be made within 120 days of the sequestration order. To the extent that formula allocations differ at different levels of budgetary resources within an account, program, project, or activity, the sequestration shall be interpreted as producing a lower total appropriation, with the remaining amount of the appropriation being obligated in a manner consistent with program allocation formulas in substantive law.

“(4) Except as otherwise provided, obligations in sequestered accounts shall be reduced only in the fiscal year in which a sequester occurs.

“(5) If an automatic spending increase is sequestered, the increase (in the applicable index) that was disregarded as a result of that sequestration shall not be taken into account in any subsequent fiscal year.

“(6) Except as otherwise provided, sequestration in trust and special fund accounts for which obligations are indefinite shall be taken in a manner to ensure that obligations in the fiscal year of a sequestration are reduced, from the level that would actually have occurred, by the applicable sequestration percentage.”.

(3) Section 256 of such Act is amended by striking “section 252” each place it appears and by inserting “section 254”. 2 USC 906.

(4) Section 256(c) (as redesignated) of such Act is amended by inserting after the first sentence the following: “No State’s matching payments from the Federal Government for foster care maintenance payments or for adoption assistance maintenance payments may be reduced by a percentage exceeding the applicable domestic sequestration percentage.”.

(5) Section 256(d)(1) of such Act is amended to read as follows:

“(1) CALCULATION OF REDUCTION IN INDIVIDUAL PAYMENT AMOUNTS.—To achieve the total percentage reduction in those programs required by sections 252 and 253, and notwithstanding section 710 of the Social Security Act, OMB shall determine, and the applicable Presidential order under section 254 shall implement, the percentage reduction that shall apply to payments under the health insurance programs under title XVIII of the Social Security Act for services furnished after the order is issued, such that the reduction made in payments under that order shall achieve the required total percentage reduction in those payments for that fiscal year as determined on a 12-month basis.”.

(6) Section 256(d)(2)(C) of such Act is repealed.

(e) THE BASELINE.—(1) Section 257 of such Act is amended to read as follows: 2 USC 907.

“SEC. 257. THE BASELINE.

“(a) IN GENERAL.—For any budget year, the baseline refers to a projection of current-year levels of new budget authority, outlays, revenues, and the surplus or deficit into the budget year and the outyears based on laws enacted through the applicable date.

“(b) DIRECT SPENDING AND RECEIPTS.—For the budget year and each outyear, the baseline shall be calculated using the following assumptions:

“(1) IN GENERAL.—Laws providing or creating direct spending and receipts are assumed to operate in the manner specified in those laws for each such year and funding for entitlement authority is assumed to be adequate to make all payments required by those laws.

“(2) EXCEPTIONS.—(A) No program with estimated current-year outlays greater than \$50 million shall be assumed to expire in the budget year or outyears.

“(B) The increase for veterans’ compensation for a fiscal year is assumed to be the same as that required by law for veterans’

(D) in subsection (c), by striking “when” and inserting “When”;

(E) in subsection (c)(1), by striking “(d)(1)(A) or (d)(1)(D) of section 20001 of the Consolidated Omnibus Budget Reconciliation Act of 1985” and inserting “(b)(1)(A), (b)(1)(B), (b)(1)(D), (b)(1)(E), or (b)(1)(F)”;

(F) in subsection (c)(2), by striking “this resolution” and inserting “this subsection”.

(5) The table of contents for the Congressional Budget and Impoundment Control Act of 1974 is amended by adding after the item for section 312 the following new item:

“Sec. 313. Extraneous matter in reconciliation legislation.”.

Subtitle C—Social Security

SEC. 13301. OFF-BUDGET STATUS OF OASDI TRUST FUNDS.

(a) **EXCLUSION OF SOCIAL SECURITY FROM ALL BUDGETS.**—Notwithstanding any other provision of law, the receipts and disbursements of the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund shall not be counted as new budget authority, outlays, receipts, or deficit or surplus for purposes of—

(1) the budget of the United States Government as submitted by the President,

(2) the congressional budget, or

(3) the Balanced Budget and Emergency Deficit Control Act of 1985.

(b) **EXCLUSION OF SOCIAL SECURITY FROM CONGRESSIONAL BUDGET.**—Section 301(a) of the Congressional Budget Act of 1974 is amended by adding at the end the following: “The concurrent resolution shall not include the outlays and revenue totals of the old age, survivors, and disability insurance program established under title II of the Social Security Act or the related provisions of the Internal Revenue Code of 1986 in the surplus or deficit totals required by this subsection or in any other surplus or deficit totals required by this title.”.

SEC. 13302. PROTECTION OF OASDI TRUST FUNDS IN THE HOUSE OF REPRESENTATIVES.

(a) **IN GENERAL.**—It shall not be in order in the House of Representatives to consider any bill or joint resolution, as reported, or any amendment thereto or conference report thereon, if, upon enactment—

(1)(A) such legislation under consideration would provide for a net increase in OASDI benefits of at least 0.02 percent of the present value of future taxable payroll for the 75-year period utilized in the most recent annual report of the Board of Trustees provided pursuant to section 201(c)(2) of the Social Security Act, and (B) such legislation under consideration does not provide at least a net increase, for such 75-year period, in OASDI taxes of the amount by which the net increase in such benefits exceeds 0.02 percent of the present value of future taxable payroll for such 75-year period,

(2)(A) such legislation under consideration would provide for a net increase in OASDI benefits (for the 5-year estimating period for such legislation under consideration), (B) such net increase,

together with the net increases in OASDI benefits resulting from previous legislation enacted during that fiscal year or any of the previous 4 fiscal years (as estimated at the time of enactment) which are attributable to those portions of the 5-year estimating periods for such previous legislation that fall within the 5-year estimating period for such legislation under consideration, exceeds \$250,000,000, and (C) such legislation under consideration does not provide at least a net increase, for the 5-year estimating period for such legislation under consideration, in OASDI taxes which, together with net increases in OASDI taxes resulting from such previous legislation which are attributable to those portions of the 5-year estimating periods for such previous legislation that fall within the 5-year estimating period for such legislation under consideration, equals the amount by which the net increase derived under subparagraph (B) exceeds \$250,000,000;

(3)(A) such legislation under consideration would provide for a net decrease in OASDI taxes of at least 0.02 percent of the present value of future taxable payroll for the 75-year period utilized in the most recent annual report of the Board of Trustees provided pursuant to section 201(c)(2) of the Social Security Act, and (B) such legislation under consideration does not provide at least a net decrease, for such 75-year period, in OASDI benefits of the amount by which the net decrease in such taxes exceeds 0.02 percent of the present value of future taxable payroll for such 75-year period, or

(4)(A) such legislation under consideration would provide for a net decrease in OASDI taxes (for the 5-year estimating period for such legislation under consideration), (B) such net decrease, together with the net decreases in OASDI taxes resulting from previous legislation enacted during that fiscal year or any of the previous 4 fiscal years (as estimated at the time of enactment) which are attributable to those portions of the 5-year estimating periods for such previous legislation that fall within the 5-year estimating period for such legislation under consideration, exceeds \$250,000,000, and (C) such legislation under consideration does not provide at least a net decrease, for the 5-year estimating period for such legislation under consideration, in OASDI benefits which, together with net decreases in OASDI benefits resulting from such previous legislation which are attributable to those portions of the 5-year estimating periods for such previous legislation that fall within the 5-year estimating period for such legislation under consideration, equals the amount by which the net decrease derived under subparagraph (B) exceeds \$250,000,000.

(b) APPLICATION.—In applying paragraph (3) or (4) of subsection (a), any provision of any bill or joint resolution, as reported, or any amendment thereto, or conference report thereon, the effect of which is to provide for a net decrease for any period in taxes described in subsection (c)(2)(A) shall be disregarded if such bill, joint resolution, amendment, or conference report also includes a provision the effect of which is to provide for a net increase of at least an equivalent amount for such period in medicare taxes.

(c) DEFINITIONS.—For purposes of this subsection:

(1) The term "OASDI benefits" means the benefits under the old-age, survivors, and disability insurance programs under title II of the Social Security Act.

(2) The term “OASDI taxes” means—

(A) the taxes imposed under sections 1401(a), 3101(a), and 3111(a) of the Internal Revenue Code of 1986, and

(B) the taxes imposed under chapter 1 of such Code (to the extent attributable to section 86 of such Code).

(3) The term “medicare taxes” means the taxes imposed under sections 1401(b), 3101(b), and 3111(b) of the Internal Revenue Code of 1986.

(4) The term “previous legislation” shall not include legislation enacted before fiscal year 1991.

(5) The term “5-year estimating period” means, with respect to any legislation, the fiscal year in which such legislation becomes or would become effective and the next 4 fiscal years.

(6) No provision of any bill or resolution, or any amendment thereto or conference report thereon, involving a change in chapter 1 of the Internal Revenue Code of 1986 shall be treated as affecting the amount of OASDI taxes referred to in paragraph (2)(B) unless such provision changes the income tax treatment of OASDI benefits.

SEC. 13303. SOCIAL SECURITY FIREWALL AND POINT OF ORDER IN THE SENATE.

(a) CONCURRENT RESOLUTION ON THE BUDGET.—Section 301(a) of the Congressional Budget Act of 1974 is amended by striking “and” at the end of paragraph (4), by striking the period at the end of paragraph (5) and inserting a semicolon; and by adding after paragraph (5) the following new paragraphs: 2 USC 632.

“(6) For purposes of Senate enforcement under this title, outlays of the old-age, survivors, and disability insurance program established under title II of the Social Security Act for the fiscal year of the resolution and for each of the 4 succeeding fiscal years; and

“(7) For purposes of Senate enforcement under this title, revenues of the old-age, survivors, and disability insurance program established under title II of the Social Security Act (and the related provisions of the Internal Revenue Code of 1986) for the fiscal year of the resolution and for each of the 4 succeeding fiscal years.”.

(b) POINT OF ORDER.—Section 301(i) of the Congressional Budget Act of 1974 is amended to read as follows:

“(i) It shall not be in order in the Senate to consider any concurrent resolution on the budget as reported to the Senate that would decrease the excess of social security revenues over social security outlays in any of the fiscal years covered by the concurrent resolution. No change in chapter 1 of the Internal Revenue Code of 1986 shall be treated as affecting the amount of social security revenues unless such provision changes the income tax treatment of social security benefits.”.

(c) COMMITTEE ALLOCATIONS.—

(1) Section 302(a)(2) of the Congressional Budget Act of 1974 is amended by inserting after “appropriate levels of” the following: “social security outlays for the fiscal year of the resolution and for each of the 4 succeeding fiscal years,”. 2 USC 633.

(2) Section 302(f)(2) of the Congressional Budget Act of 1974 is amended by inserting before the period the following: “or provides for social security outlays in excess of the appropriate allocation of social security outlays under subsection (a) for the

fiscal year of the resolution or for the total of that year and the 4 succeeding fiscal years”.

2 USC 633.

(3) Section 302(f)(2) of such Act is further amended by adding at the end the following: “In applying this paragraph—

“(A) estimated social security outlays shall be deemed to be reduced by the excess of estimated social security revenues (including social security revenues provided for in the bill, resolution, amendment, or conference report with respect to which this paragraph is applied) over the appropriate level of social security revenues specified in the most recently adopted concurrent resolution on the budget;

“(B) estimated social security outlays shall be deemed increased by the shortfall of estimated social security revenues (including social security revenues provided for in the bill, resolution, amendment, or conference report with respect to which this paragraph is applied) below the appropriate level of social security revenues specified in the most recently adopted concurrent resolution on the budget; and

“(C) no provision of any bill or resolution, or any amendment thereto or conference report thereon, involving a change in chapter 1 of the Internal Revenue Code of 1986 shall be treated as affecting the amount of social security revenues unless such provision changes the income tax treatment of social security benefits.

The Chairman of the Committee on the Budget of the Senate may file with the Senate appropriately revised allocations under subsection (a) and revised functional levels and aggregates to reflect the application of the preceding sentence. Such revised allocations, functional levels, and aggregates shall be considered as allocations, functional levels, and aggregates contained in the most recently agreed to concurrent resolution on the budget, and the appropriate committees shall report revised allocations pursuant to subsection (b).”.

2 USC 642.

(d) POINT OF ORDER UNDER SECTION 311.—(1) Subsection (a) of section 311(a) of the Congressional Budget Act of 1974 is redesignated as subsection (a)(1) and paragraphs (1), (2), and (3) are redesignated as subparagraphs (A), (B), and (C).

(2) Section 311(a) of such Act is amended by inserting at the end the following new paragraph:

“(2)(A) After the Congress has completed action on a concurrent resolution on the budget, it shall not be in order in the Senate to consider any bill, resolution, amendment, motion, or conference report that would cause the appropriate level of total new budget authority or total budget outlays or social security outlays set forth for the first fiscal year in the most recently agreed to concurrent resolution on the budget covering such fiscal year to be exceeded, or would cause revenues to be less than the appropriate level of total revenues (or social security revenues to be less than the appropriate level of social security revenues) set forth for the first fiscal year covered by the resolution and for the period including the first fiscal year plus the following 4 fiscal years in such concurrent resolution.

“(B) In applying this paragraph—

“(i)(I) estimated social security outlays shall be deemed to be reduced by the excess of estimated social security revenues (including those provided for in the bill, resolution, amendment, or conference report with respect to which this subsection is applied) over the appropriate level of Social Security revenues

specified in the most recently agreed to concurrent resolution on the budget;

“(II) estimated social security revenues shall be deemed to be increased to the extent that estimated social security outlays are less (taking into account the effect of the bill, resolution, amendment, or conference report to which this subsection is being applied) than the appropriate level of social security outlays in the most recently agreed to concurrent resolution on the budget; and

“(ii)(I) estimated Social Security outlays shall be deemed to be increased by the shortfall of estimated social security revenues (including Social Security revenues provided for in the bill, resolution, amendment, or conference report with respect to which this subsection is applied) below the appropriate level of social security revenues specified in the most recently adopted concurrent resolution on the budget; and

“(II) estimated social security revenues shall be deemed to be reduced by the excess of estimated social security outlays (including social security outlays provided for in the bill, resolution, amendment, or conference report with respect to which this subsection is applied) above the appropriate level of social security outlays specified in the most recently adopted concurrent resolution on the budget; and

“(iii) no provision of any bill or resolution, or any amendment thereto or conference report thereon, involving a change in chapter 1 of the Internal Revenue Code of 1986 shall be treated as affecting the amount of social security revenues unless such provision changes the income tax treatment of social security benefits.

The chairman of the Committee on the Budget of the Senate may file with the Senate appropriately revised allocations under section 302(a) and revised functional levels and aggregates to reflect the application of the preceding sentence. Such revised allocations, functional levels, and aggregates shall be considered as allocations, functional levels, and aggregates contained in the most recently agreed to concurrent resolution on the budget, and the appropriate committees shall report revised allocations pursuant to section 302(b).”

SEC. 13304. REPORT TO THE CONGRESS BY THE BOARD OF TRUSTEES OF THE OASDI TRUST FUNDS REGARDING THE ACTUARIAL BALANCE OF THE TRUST FUNDS.

Section 201(c) of the Social Security Act (42 U.S.C. 401(c)) is amended by inserting after the first sentence following clause (5) the following new sentence: “Such statement shall include a finding by the Board of Trustees as to whether the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund, individually and collectively, are in close actuarial balance (as defined by the Board of Trustees).”.

SEC. 13305. EXERCISE OF RULEMAKING POWER.

2 USC 900 note.

This title and the amendments made by it are enacted by the Congress—

(1) as an exercise of the rulemaking power of the House of Representatives and the Senate, respectively, and as such they shall be considered as a part of the rules of each House, respectively, or of that House to which they specifically apply,

(4) The Congressional Budget Office shall be exempt from section 203 of the Congressional Budget Act of 1974 with respect to any book, record, or information made available under this subsection and determined by the Director to be confidential under paragraph (1).

(f) **REQUIREMENT TO REPORT LEGISLATION.**—(1) The committees of jurisdiction in the House shall prepare and report to the House no later than September 15, 1991, legislation to ensure the financial soundness of GSEs and to minimize the possibility that a GSE might require future assistance from the Government.

(2) It is the sense of the Senate that the committees of jurisdiction in the Senate shall prepare and report to the Senate no later than September 15, 1991, legislation to ensure the financial safety and soundness of GSEs and to minimize the possibility that a GSE might require future assistance from the Government.

(f) **PRESIDENT'S BUDGET.**—The President's annual budget submission shall include an analysis of the financial condition of the GSEs and the financial exposure of the Government, if any, posed by GSEs.

Approved November 5, 1990.

Certified February 22, 1991.

Editorial note: This printed version of the original hand enrollment is published pursuant to section 2(c) of Public Law 101-466. The following memorandum for the Archivist of the United States was signed by the President on January 10, 1991, and was printed in the *Federal Register* on January 14, 1991:

By the authority vested in me as President by the Constitution and laws of the United States, including Section 301 of Title 3 of the United States Code, I hereby authorize you to ascertain whether the printed enrollment of H.R. 5835, the Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508), approved on November 5, 1990, is a correct printing of the hand enrollment and if so to make on my behalf the certification specified in Section 2(c) of H.J. Res. 682 (Public Law 101-466).

Attached is the printed enrollment that was received at the White House on January 7, 1991.

This memorandum shall be published in the *Federal Register*.

The Archivist on February 22, 1991, certified this to be a correct printing of the hand enrollment of Public Law 101-508.

LEGISLATIVE HISTORY—H.R. 5835 (S. 3209):

HOUSE REPORTS: No. 101-881 (Comm. on the Budget) and No. 101-964 (Comm. of Conference).

CONGRESSIONAL RECORD, Vol. 136 (1990):

Oct. 16, considered and passed House.

Oct. 17, S. 3209 considered in Senate.

Oct. 18, H.R. 5835 considered and passed Senate, amended, in lieu of S. 3209.

Oct. 26, House agreed to conference report.

Oct. 27, Senate agreed to conference report.

WEEKLY COMPILATION OF PRESIDENTIAL DOCUMENTS, Vol. 26 (1990):

Nov. 5, Presidential statement.

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